Print Form

ENROLMENT FORM

Certificate # _____

PLEASE PRINT AND COMPLETE EACH SECTION CLEARLY IN INK.
REMIT SIGNED ORIGINAL TO RWAM AND KEEP A COPY FOR YOUR RECORDS.

EMPLOYER DATA

Employer _____ Group# _____ Div.# _____ Class _____ ☐ New ☐ Reinstatement

Permanent Full-time Hire Date (yy/mm/dd)
(Reinstatements indicate date of re-hire) _____ Description of Occupation _____

Earnings _____ ☐ Salary (annual) ☐ Bi-Weekly ☐ Weekly ☐ Hourly ☐ Monthly Hours worked (per week) _____
(Excluding Bonus/Dividend/Overtime Income)

EMPLOYEE STATEMENT

You and your dependents must be insured under your Provincial Benefit Plan in order to participate in RWAM's group insurance plan.

Employee's Surname _____ First Name _____

Date of Birth (yy/mm/dd) _____ Sex ☐ Female ☐ Male Address _____

Marital Status
☐ Single ☐ Common-law* ☐ Separated ☐ Married ☐ Divorced ☐ Widowed

*If Common-law, indicate date co-habitation began (yy/mm/dd) _____

☐ **SINGLE, Extended Health Care**
☐ **SINGLE, Dental**

If you are eligible for family coverage your dependents must have coverage* through your spouse
Spouse's Employer _____
Spouse's Group Insurance Carrier _____

☐ **FAMILY, Extended Health Care**
☐ **FAMILY, Dental**

Please indicate if you have coverage* through your spouse
E.H.C. ☐ No ☐ Yes
Dental ☐ No ☐ Yes
If 'Yes' indicate Spouse's Group Insurance Carrier _____

Claims must be submitted to the primary carrier first. Any portion of the claim not reimbursed by the primary carrier should be sent to the secondary carrier for consideration. Children's claims are reimbursed by the plan of the parent whose date of birth falls first in the calendar year.

☐ **WAIVE, Extended Health Care**
☐ **WAIVE, Dental**

To waive coverage you and your dependents must have coverage* through your spouse.
Spouse's Employer _____
Spouse's Group Insurance Carrier _____

* If comparable coverage ceases, you must notify RWAM within 31 days or you will be subject to medical evidence (at your expense) and a one year dental restriction.

ELIGIBLE DEPENDENTS

	Name (state surname if different than employee's)	Date of Birth (yy/mm/dd)		Name (state surname if different than employee's)	Relationship to Employee	Date of Birth (yy/mm/dd)
Spouse			Children*			

Students aged 21 or over and under 25 (or as specified in your plan) are only eligible if they submit confirmation of full-time registration.

*Children of common-law spouses must reside with the employee to be eligible.

BENEFICIARY DESIGNATION

I revoke all prior beneficiary designations under this certificate. I hereby designate the following person(s) to receive all group life insurance benefits payable on my death. If more than 1 person is named, proceeds are to be shared equally, unless otherwise stated below. A separate Beneficiary Designation/Change form is required to name contingent beneficiaries.

Beneficiary (ies) *→

Name(s) (first, middle initial, last)	Relationship to Insured	% Shares (must = 100%)	
			%
			%
			%

Trustee *** If a beneficiary is under age 18**: Consider naming a Trustee as benefits cannot be paid to a minor. Benefits will be paid to the named Trustee (regardless of beneficiary age) unless you change the designation to remove the Trustee.

Trustee Name (first, middle initial, last)	As Trustee for (beneficiary name)	Relationship to Beneficiary

AUTHORIZATION

I understand the information I provide on this form will be used by RWAM Insurance Administrators Inc.(RWAM) and the insurer for the purposes of determining eligibility for group insurance coverage and benefits; and to administer benefits under this coverage. I hereby authorize my employer/plan administrator, the authorized group agent/broker, and the insurer to exchange any relevant and necessary information for such purposes. If I am applying for coverage for my eligible dependents, I confirm I am authorized to act on their behalf for such purposes. I declare that the statements made on this form are complete and true. I understand that if any statement is incomplete or false, any coverage granted may be voided. This authorization will remain valid for as long as I am claiming benefits or service, or until revoked by myself.

Employee's Signature X _____ Date _____ (yy/mm/dd)

OFFICE USE ONLY

Effective Date	Life Volume ☐ GF	WI Volume ☐ GF	LTD Volume ☐ GF	Extended Health Care ☐ Single ☐ Family ☐ Nil	Dental ☐ Single ☐ Family ☐ Nil

FOR ELECTRONIC DEPOSIT OF BENEFITS COMPLETE EFT APPLICATION (RA014)