

# Critical • Choice • Care™ Enrollment Card



## Employer Section

Policy No. .... Division/Unit .....

Employer .....

## Applicant Section

Employee's Name ..... Province of Residence .....

Applicant's Name ..... Date of Birth M D Y .....

(Employee) Sex:  M  F  Smoker  Non-Smoker

Amount of Principal Sum: .....

Signature ..... Date M D Y .....

Applicant's Name ..... Date of Birth M D Y .....

(Spouse) Sex:  M  F  Smoker  Non-Smoker

Amount of Principal Sum: .....

Signature ..... Date M D Y .....

New Insurance  Change in Amount  Change in Name

I authorize the deduction from my salary of the premiums for the insurance applied for as shown above.  I have been given the opportunity to apply for this insurance but I do not desire to participate.

Employee's Signature ..... Date M D Y .....

25709 (06.06)