



INDIVIDUAL APPLICATION FOR GROUP INSURANCE

OFFICE USE ONLY
Cert # _____
Div # _____
Class # _____

EMPLOYER: Name _____ Province _____

Applicant's Surname _____ First Name _____ Middle Name _____

Birth date(mm/dd/yyyy) _____ Sex: M / F _____

Address: _____ City or Town _____ Province of Residence _____ Postal Code _____

(_____) _____
Home Telephone Number

Dependents age 21 and over but under age 25 must be full-time students. If applicable, please complete the Confirmation of School Attendance form.

EMPLOYEES MUST ENROLL ACCORDING TO THEIR TRUE FAMILY STATUS

	FIRST NAME	LAST NAME (if different)	Sex M/F	Student Y/N	Birth date (mm/dd/yyyy)
Spouse or Common Law					/ /
Dependent Children					/ /
					/ /
					/ /
					/ /

TYPE OF COVERAGE: SINGLE FAMILY

WHAT GROUP BENEFITS COVERAGE DOES MY SPOUSE HAVE THROUGH HIS/HER EMPLOYER?

EXTENDED HEALTH CARE

Single Family Waived None

DENTAL

Single Family Waived None

WAIVER: I am insured for Extended Health Care (EHC) Dental under my spouse's group insurance plan and therefore I am not applying for these benefits.

Note: EHC and Dental coverage can only be refused if you and/or your dependents are covered by duplicate group benefits through your spouse's employer.

COMPLETE THE FOLLOWING IF WAIVING EHC AND/OR DENTAL COVERAGE:

Spouse's Insurance Carrier(s): _____

Spouse's Group Policy number(s): _____

If you lose spousal coverage you must apply for coverage within 31 days of loss of such coverage. If you do not apply within 31 days you and your dependents may be required to provide proof of insurability acceptable to the Insurer to be covered. If you are approved, coverage for dental benefits may be limited. Please see your plan administrator for details.

BENEFICIARY: I reserve the right to change the beneficiary at any time, unless otherwise provided by contract.

Full Name	Date of Birth (mm/dd/yy)	Relationship to employee	Proportion
			%
			%
			%

Please indicate relationship to beneficiary. If a minor, indicate date of birth and assign trustee below. If additional space is required, please attach a separate page.

TRUSTEE: _____, my _____ if living, is hereby appointed trustee to receive and disburse any moneys payable to a child aforesaid of minority. Any payment made to said trustee shall discharge the company to the extent of such payment.

I hereby apply for coverage under the *CoreLink* benefits plan arranged by my employer. I authorize:

- My employer to deduct from my pay and remit the plan member contributions required under the plan, if applicable;
- The insurance carriers to use my information collected on this form to underwrite, administer, and adjudicate claims.
- The insurance carriers, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations, or service providers working with the insurance carriers to exchange personal information, when necessary to determine my eligibility for coverage and to administer the plan.

I am authorized to disclose information about my spouse and dependents in order to enrol them in the Plan. All information in this form is true and complete. **I agree to the Authorization and Consent on the reverse side of this form.**

Applicant's Signature: _____ **Date:** _____

TO BE COMPLETED BY THE PLAN ADMINISTRATOR:

Date of Employment (permanent): ____/____/____ Effective Date: ____/____/____
(MM / DD / YYYY) of coverage (MM / DD / YYYY)

New Enrollment Reinstatement Number of hours worked per week: _____

Job Title: _____ Earnings: \$ _____ per _____

Employer Signature: _____ Date: _____

Please mail the original completed in ink to:
Rice Financial Group Inc., ATTN: Employee Benefits, 491 Portage Ave., Winnipeg, MB R3B 2E4
Please keep a photocopy for your records.

AUTHORIZATION AND CONSENT

I understand that the personal information provided herein as well as any other personal information currently held or collected in the future by Rice Financial Group Inc. and the insurance carriers of my group insurance policy may be collected, used, or disclosed to administer the terms of the group policy of which I am an eligible member, to develop and recommend suitable products and services to me and my employer, and to manage the organization's business.

Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These include the insurance carriers of my group insurance policy, licensed physicians and/or any other health care professionals or institutions, health and life insurers, government and regulatory authorities, and other third parties when required to administer the benefits outlined in the group policy of which I am an eligible member.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, the coverage may be declined or rescinded. I understand why my personal information is needed and am aware of the risks and benefits or consenting or refusing to consent to its disclosure. For additional information regarding Rice Financial Group Inc.'s Group Benefits privacy policy I can contact Rice Financial at 204-786-0324 or privacy@ricefinancial.com should I have questions as to the collection, use or disclosure of my personal information.