

EMPLOYMENT INFORMATION:										Policy Holder's Name: SMARTCHOICE BENEFITS FOR BUSINESSES																																							
Employer																																																	
Division (if applicable)										Province																																							
Date of full-time employment (YYYY/MM/DD)										Annual Income										# of Hours/Week																													
Occupation																																																	
EMPLOYEE INFORMATION:										Effective Date of Coverage (DD/MM/YYYY)										Class:																													
Last Name																																																	
First Name																																																	
Birthdate (YYYY/MM/DD)										Gender										<input type="checkbox"/> Male <input type="checkbox"/> Female										Language Preference										<input type="checkbox"/> English <input type="checkbox"/> French									
SPOUSAL INFORMATION (If applicable):																																																	
Last Name																																																	
First Name																																																	
Birthdate (YYYY/MM/DD)										Gender										<input type="checkbox"/> Male <input type="checkbox"/> Female										Language Preference										<input type="checkbox"/> English <input type="checkbox"/> French									
GENERAL INFORMATION:										Email Address:																																							
										Home /Residence Phone Number:																																							
Marital Status										<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Common law (cohabited for at least 12 months)																																							
Home Address																																																	
City										Province										Postal Code																													
CHILDREN'S INFORMATION (if applicable):																																																	
Dependent Coverage: Name & Gender of Children Required and Proof of full-time registration is required for an Overage Dependent Age 21 or over but under Age 26, who is a full-time student attending an accredited educational institution, college or university. Proof of registration includes a copy of approved enrollment or copy of school identification card and will be required prior to the beginning of each school year.																																																	
Child's Last Name:					First Name:					Gender					Birthdate (YYYY/MM/DD)					Full-Time Student																													
										<input type="checkbox"/> Male <input type="checkbox"/> Female										<input type="checkbox"/> Yes <input type="checkbox"/> No																													
										<input type="checkbox"/> Male <input type="checkbox"/> Female										<input type="checkbox"/> Yes <input type="checkbox"/> No																													
										<input type="checkbox"/> Male <input type="checkbox"/> Female										<input type="checkbox"/> Yes <input type="checkbox"/> No																													
The information being collected will be used to provide benefit coverage for an employee's eligible spouse or benefit partner and children. It is protected by the privacy provisions of the Personal Information Protection and Electronic Documents Act. If you have any questions about the collection and use of this information, contact your Plan Administrator. You are responsible for advising your Plan Administrator of any changes to your dependent information.																																																	
BENEFICIARY					Last Name					First Name					Birthdate (YYYY/MM/DD)					Relationship																													
Employee's																																																	
Spouse's																																																	
Children's																																																	
IMPORTANT: If a beneficiary is not assigned, "Estate" will be assumed. *For Quebec residents only. If the beneficiary is shown as irrevocable, his/her consent is required to change it. In Quebec the designation of your spouse as beneficiary is irrevocable unless otherwise specified. <input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable																																																	
Authorization and Signature																																																	
I certify that the information given on this form is true, correct and complete to the best of my knowledge. I understand that I may be required to provide proof of evidence of this information. I hereby accept the conditions of this policy and I authorize the necessary contributions to be made through salary deductions, if applicable. I authorize my Employer, the Policyholder, the Plan Administrator and the Insurance Company (ies) or their re-insurers, or their respective agents to give, receive and share any personal information regarding my eligibility and my insurability or those of my dependents, if any under this plan. In the case of death, I expressly authorize my Employer, the Policyholder, the Plan Administrator, the Beneficiary, heir or liquidator of my estate to provide the Life Insurance Company, when required by the latter, with all the information and authorizations permitting the assessment of the claim and collection of evidence. This consent is valid for the purpose of this contract, or any modification, extension or reinstatement thereof. A photocopy of this consent is valid as the original if it is used for information-sharing purposes.																																																	
PLEASE SIGN HERE ➔										Employee's Signature										Date																													
																				Y Y Y Y M M D D																													