SmartChoice BENEFITS

GROUP BENEFITS REFUSAL OF ALL COVERAGE

1 General Information

Plan sponsor name

Plan contract number | Account/Division number | Account/Division name

Employee last name | Middle initial | Employee First name

Date of birth (mm/dd/yyyy) | Full Time Hire Date (mm/dd/yyyy)

Comments

2 Certification and authorization

Please print clearly, in INK

I have been given an opportunity to participate in the Group Benefits Program offered by my employer.

The benefits of the plan have been explained to me and after careful consideration, I have decided to refuse the coverage under the Group Insurance Plan. I understand that as a result I and/or my dependents are not entitled to make any claim for benefits under this plan.

I further understand that if I wish to apply for the refused coverages at a later date I will be required to provide at, my own expense, satisfactory proof of good health for myself and any eligible dependents, if any.

However the insurance provider retains the right to refuse my application for coverage. If coverage is approved, dental benefits (if any) will be limited during the first 12 months of coverage.

Employee signature | Date signed(mm/dd/yyyy)

Spouse signature (If applicable) | Date signed (mm/dd/yyyy)

Plan administrator signature | Date signed (mm/dd/yyyy)

3 Mailing Instructions

Please retain a copy for your records and mail the original signed form to :

SmartChoice Benefits Inc.
25 North Rivermede Road, Unit #19, Concord, Ontario L4K 5V4
Tel. : 1 (800) 567-0516 Fax : (905) 660-4199