AGA BENEFIT SOLUTIONS

ENROLMENT FORM
Including Optional Dental Care Benefit

☞ *Quebec residents: before completing this section, please refer to the "Bill 33" document on reverse*

ADMINISTRATIVE INFORMATION

Employer / Policyholder name	Group No.	Division No.	Class	Department

Employee's last name	First Name	Employee No.

Date of birth (YYYY – MM - DD)

Sex : ☐ M ☐ F

Civil status : ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
☐ Common-law spouse ⇨ Cohabitation since (YYYY – MM – DD) _____

Address (No. / Street / Apt.)	Email

City	Province	Postal code	Telephone

Date of full-time employment (YYYY – MM - DD)	Date of eligibility for Insurance (YYYY – MM - DD)	Occupation	Earnings : $_____ ☐ Annual ☐ Weekly ☐ Hourly ⇨ # hours/week _____

☐ **YES, I would like to receive my claim reimbursements directly into my bank account.**
It is the responsibility of the member to ensure the accuracy of the banking information entered on the Enrolment form.
If banking information is incorrect, please note that AGA cannot be held responsible for amounts not received by the member.

Branch	Bank	Account number

REQUIRED COVERAGE AND INFORMATION ON SPOUSE AND/OR CHILDREN

Health care: ☐ Single ☐ Single parent ☐ Couple ☐ Family ☐ Opt-out ⇨ Reason : _____

Dependent Life benefit:
(if it is part of your plan)

Do you want to cover your dependent for Dependent Life benefit? ☐ Yes ☐ No
(This benefit may be mandatory with some insurers if you have eligible spouse and/or children)

Optional benefits:
If offered under your plan and under its conditions.

Subject to insurer's approval.
Evidence of insurability for Optional Life must be completed and returned to AGA.

Optional Life insurance : ☐ Amount requested : $ _____

Optional Dependent Life benefit : ☐ Amount requested : $ _____

Optional Accidental death and dismemberment benefit : ☐ Amount requested : $ _____

Optional Dental Care Benefit ☐ Single ☐ Single parent ☐ Couple ☐ Family

This benefit must be maintained for a 24 month period for yourself and your dependents, unless there is a change related to the eligibility conditions specified in the main policy.

SPOUSE AND/OR CHILDREN IDENTIFICATION

The Dependent Life benefit coverage, if part of your plan, may be mandatory with some insurers if you have eligible spouse and/or children.
You must indicate all information regarding your eligible spouse and/or children even if you choose a "Single" coverage or if you choose to "Opt-out".

	Last name	First name	Sex M	Sex F	Date of birth (YYYY – MM - DD)	21 years of age or more, please specify:		Are the spouse/children covered by another plan? Health care Yes	Health care No	Dental care Yes	Dental care No
Spouse			☐	☐		Full-time student	Handicapped	☐	☐	☐	☐
Child 1			☐	☐		☐	☐	☐	☐	☐	☐
Child 2			☐	☐		☐	☐	☐	☐	☐	☐
Child 3			☐	☐		☐	☐	☐	☐	☐	☐
Child 4			☐	☐		☐	☐	☐	☐	☐	☐
Child 5			☐	☐		☐	☐	☐	☐	☐	☐
Child 6			☐	☐		☐	☐	☐	☐	☐	☐

If you have answered "Yes" to the question: "Are your children covered by another plan?", please confirm details on the back of this page.
This information is necessary to apply the rules for the coordination of benefits.

BENEFICIARY DESIGNATION

Failing to designate a beneficiary, the death benefit will be paid to the estate

Beneficiary's last name	First name	Date of birth (YYYY – MM - DD)	Relationship

For Quebec participants only

The designation of your spouse (married or civil union) as beneficiary is irrevocable unless otherwise specified. If the beneficiary is shown as irrevocable, his/her consent will be required to change it. If spouse is beneficiary, designation is: ☐ **revocable** ☐ **irrevocable**

There might be issues with respect to the appointment of a **trustee** as beneficiary. You should consult a legal advisor regarding this matter.

AUTHORIZATION AND SIGNATURE

Please take note of the "Notice regarding personal information confidentiality" on reverse

☐ I hereby request coverage under my employer/policyholder's group insurance plan subject to the contract terms and conditions and authorize my employer/policyholder to deduct the required contributions from my earnings. I also authorize my employer/policyholder, the insurer and their respective representatives and mandatories 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 event of death, I authorize my beneficiaries, heirs or estate liquidators to give any personal information or authorizations deemed necessary to the plan administrator, insurer or its reinsurers for claim study purposes and in obtaining required proofs.

Employee's signature	Date

Children covered by another plan – Please provide the following details:

Indicate for which child the following applies – Child # : _____

Health care	Dental care
☐ Coverage by the plan of current spouse ☐ Coverage by the plan of the other parent ☐ Coverage by the plan of the spouse of the other parent ☐ Coverage by the plan of the other parent and the spouse of the other parent ☐ Coverage by the plan of an educational institution: ☐ including drug coverage ☐ excluding drug coverage	☐ Coverage by the plan of current spouse ☐ Coverage by the plan of the other parent ☐ Coverage by the plan of the spouse of the other parent ☐ Coverage by the plan of the other parent and the spouse of the other parent ☐ Coverage by the plan of an educational institution
If the parents are separated, divorced or not living together : Are you the sole custodial parent? ☐ **or** Does the other parent have sole custodial? ☐ **or** Do you have shared custody? ☐ If you share custody, please indicate other parent's date of birth : (YYYY/MM/DD) : _____	***If the parents are separated, divorced or not living together :*** Are you the sole custodial parent? ☐ **or** Does the other parent have sole custodial? ☐ **or** Do you have shared custody? ☐ If you share custody, please indicate other parent's date of birth : (YYYY/MM/DD) : _____

Indicate for which child the following applies – Child # : _____

Health care	Dental care
☐ Coverage by the plan of current spouse ☐ Coverage by the plan of the other parent ☐ Coverage by the plan of the spouse of the other parent ☐ Coverage by the plan of the other parent and the spouse of the other parent ☐ Coverage by the plan of an educational institution: ☐ including drug coverage ☐ excluding drug coverage	☐ Coverage by the plan of current spouse ☐ Coverage by the plan of the other parent ☐ Coverage by the plan of the spouse of the other parent ☐ Coverage by the plan of the other parent and the spouse of the other parent ☐ Coverage by the plan of an educational institution
If the parents are separated, divorced or not living together : Are you the sole custodial parent? ☐ **or** Does the other parent have sole custodial? ☐ **or** Do you have shared custody? ☐ If you share custody, please indicate other parent's date of birth : (YYYY/MM/DD) : _____	***If the parents are separated, divorced or not living together :*** Are you the sole custodial parent? ☐ **or** Does the other parent have sole custodial? ☐ **or** Do you have shared custody? ☐ If you share custody, please indicate other parent's date of birth : (YYYY/MM/DD) : _____

Initials : _____

QUEBEC RESIDENTS ONLY
BILL 33 – "DID YOU KNOW …"

- ✓ *On January 1st, 1997, Bill 33 (Quebec Universal Drug Plan) became effective for all Quebec residents.*
- ✓ *All Quebec residents under 65 years of age that have access to a group insurance plan, are obliged to join the group plan. If a person is covered by another group plan or if a person is covered by a spouse's group plan, proof of such coverage must be filed with your employer.*
- ✓ *On the group insurance application form with your employer, you are obliged to insure all eligible dependents, spouse and children, unless these dependents are already covered by another group plan.*
- ✓ *Your eligible dependents cannot be insured with R.A.M.Q. (Quebec Universal Drug Plan) if you are covered by your employer's group plan, with the exception of a spouse, aged 65 years and over.*
- ✓ *When filing your Quebec tax return, you will be asked if you have met the requirements according to this law.*

NOTICE REGARDING PERSONAL INFORMATION CONFIDENTIALITY

As group insurance administrators, we are required to collect and maintain on file certain personal data concerning yourself. We are aware that this is an important responsibility and this is why we consider the personal information protection a priority.

The subject of Your File *– The subject-matter of your file as established at our firm bears the title "Group Insurance (Sales, Administration and Services) ". The personal information concerning you is collected in this file and is kept secure under the highest standards of confidentiality.*

Confidentiality *– We only collect relevant information needed to constitute this file for purposes of allowing us to carry out our assignment. Access to this file is limited to the firm's employees, representatives, agents, service providers and suppliers who require this information to successfully accomplish their duties. Information contained in this file cannot be disclosed without your consent; any disclosure must comply with provisions under the Act respecting the protection of personal information in the private sector. We can communicate your information to third parties who provide services on our behalf, those third parties may have their facilities in the United States or other location. Our service providers and suppliers can only use your personal information to provide the services or supplies on our behalf.*

Access *– If you wish to have access to your file, you must send a request by e-mail at: mailto:info@aga.caor communicate with us at numbers mentioned below.*

Updates and corrections *– Please keep us informed regarding any changes in information contained in this file and, if required, indicate to us in writing any correction needed to ensure accuracy.*

For further information, please do not hesitate to contact Customer Service at the following numbers :

Montreal area:	***514-935-5444***
Elsewhere in Quebec:	***1 800 363-6217***
Fax:	***514-935-1147***