



REENROLMENT FORM EVOLUTION – Modular Plan

ADMINISTRATIVE INFORMATION

Employer / Policyholder name		Group No.	Employee No.
Employee's last name	First name		Certificate No.
Address (No. / Street / Apt.)			Email
City	Province	Postal code	Telephone

Quebec residents ☞ Before completing this section, please refer to the "BILL 33" document on reverse

MODULE CHOICE

**The "staircase" rule applies. You can move up and/or down one level at a time.
If you have Opted-out, you are eligible for the SILVER module only.**

HEALTH AND/OR DENTAL CARE	<input type="checkbox"/> OPT-OUT <input type="checkbox"/> SILVER <input type="checkbox"/> GOLD <input type="checkbox"/> PLATINUM
OPTIONAL LIFE INSURANCE:	Insured: <input type="checkbox"/> Amount requested: \$ _____ Increments of \$10,000 - Minimum \$20,000 / maximum \$300,000 Spouse: <input type="checkbox"/> Amount requested: \$ _____ Increments of \$10,000 - Minimum \$20,000 / maximum \$300,000 Child: <input type="checkbox"/> Amount requested: \$ _____ Increments of \$5,000 - Minimum \$5,000 / maximum \$50,000 <p style="text-align: center;">Must be approved by the insurer - An Evidence of Insurability form must be completed and sent to AGA</p>

EMPLOYEE'S SIGNATURE

Employee's signature	Date
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Children covered by another plan – Please provide the following details:

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

<p align="center">Health care</p> <p><input type="checkbox"/> Coverage by the plan of current spouse <input type="checkbox"/> Coverage by the plan of the other parent <input type="checkbox"/> Coverage by the plan of the spouse of the other parent <input type="checkbox"/> Coverage by the plan of the other parent and the spouse of the other parent <input type="checkbox"/> Coverage by the plan of an educational institution: <input type="checkbox"/> including drug coverage <input type="checkbox"/> excluding drug coverage</p> <p><i>If the parents are separated, divorced or not living together:</i> Are you the sole custodial parent? <input type="checkbox"/> or Does the other parent have sole custodial? <input type="checkbox"/> or Do you have shared custody? <input type="checkbox"/> If you share custody, please indicate other parent's date of birth: (YYYY/MM/DD): _____</p>	<p align="center">Dental care</p> <p><input type="checkbox"/> Coverage by the plan of current spouse <input type="checkbox"/> Coverage by the plan of the other parent <input type="checkbox"/> Coverage by the plan of the spouse of the other parent <input type="checkbox"/> Coverage by the plan of the other parent and the spouse of the other parent <input type="checkbox"/> Coverage by the plan of an educational institution</p> <p><i>If the parents are separated, divorced or not living together:</i> Are you the sole custodial parent? <input type="checkbox"/> or Does the other parent have sole custodial? <input type="checkbox"/> or Do you have shared custody? <input type="checkbox"/> If you share custody, please indicate other parent's date of birth: (YYYY/MM/DD): _____</p>
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Indicate for which child the following applies – Child # : _____

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

***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***