

Plan administrator statement

I Administrative information (please print)					
Policyholder name				Policy no.	Division no.
Participant surname		Given name(s)		Initial	Certificate no.
Date of permanent full-time employment <i>(with present employer)</i> (YYYY/MM/DD)			Eligibility date of insurance (YYYY/MM/DD)		
Occupation	Class	Salary	Salary basis: <input type="checkbox"/> Annual <input type="checkbox"/> Monthly	<input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly	<input type="checkbox"/> Hourly _____ Hours worked per week
Health Spending Account					
Variable allocations		Combined: \$	or Health: \$	Dental: \$	

Participant statement

II Administrative information (please print)					
Language: <input type="checkbox"/> English <input type="checkbox"/> French	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth (YYYY/MM/DD)	Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Divorced <input type="checkbox"/> Common-law <input type="checkbox"/> Civil union
If common-law, date on which cohabitation period started (YYYY/MM/DD)					
Indian status <input type="checkbox"/> Yes <input type="checkbox"/> No	Main residence address (no., street)				Apt.
City	Province of residence	Workplace Province (if different than province of residence)		Postal code	
Telephone no. (day)			Telephone no. (evening)		
Direct deposit					
Type of bank account: <input type="checkbox"/> Chequing <i>Please complete this section or attach a personalized void cheque to ensure that we obtain your accurate banking information.</i>			Branch no.	Institution no.	Account no.
<input type="checkbox"/> Savings					
Financial institution name			Financial institution address		
Account holder signature (if other than participant)				Date (YYYY/MM/DD)	

III Information on your dependent(s)										
	Surname	Given name(s)	Gender	Date of birth (YYYY/MM/DD)	Are your spouse and/or your children covered by another group insurance plan? ¹		Full-time student ²	Total and permanent disability ³	Dependent children of	
					Health care	Dental care			Spouse	Participant
			M F		Yes No	Yes No				
Spouse			<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Child			<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Child			<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Child			<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Child			<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

¹ If your spouse and/or children are covered under another group insurance policy, please complete section IV.
² If you have dependent children who have reached the first age limit stipulated in the contract, please complete section VII.
³ If you have disabled dependent children who have reached the first age limit stipulated in the contract, please complete the Application for total and permanent disability status for a dependent child form PC GE10352 and attach it to this Application. This form can be obtained by calling us at 1-800-499-4415.

IV Information about your spouse's group insurance plan					
Name of your spouse's group insurer		Policy no.	Coverage:	Health care:	<input type="checkbox"/> Individual <input type="checkbox"/> Family
				Dental care:	<input type="checkbox"/> Individual <input type="checkbox"/> Family
V Choice of coverage					
<input type="checkbox"/> Individual coverage (only the participant is covered)			<input type="checkbox"/> Family coverage (the participant and his/her eligible dependents are covered)		

