info@ lewer.ca www.lewer.ca
3131 Saint-Martin Blvd. West, suite 410, Laval QC H7T 2Z5
(905) 821-9881 (800) 387-8244

# Employee Enrollment Form

***If this form is not completed, it could impact your eligibility for coverage. For more information please contact us by phone or email.***

**PLEASE COMPLETE NEATLY, SIGN SECTIONS FOUR AND FIVE AND RETURN THE ORIGINAL TO LEWER CANADA.**

## Section One – Information About You, to be Completed by Employee

| First Name | Middle Name | Last Name |
|---|---|---|
| | | |

| Date of Birth | Language | Gender |
|---|---|---|
| ( *Month* / *Day* / *Year* ) | Language: ❑ English ❑ French | ❑ Male ❑ Female |

Status Native Canadian

❑ Yes ❑ No (Please attach a copy of your Status Card)

Marital Status

❑ Single ❑ Married ❑ Separated ❑ Divorced

❑ Common Law ❑ Widowed ❑ Civil Union *Provide Date of Cohabitation* _____ / _____ / _____
Month Day Year

### CONTACT INFORMATION

Note: By providing your email address you are authorizing us to use this email address for communication purposes with you.

| Street Address | Apartment/Unit # |
|---|---|
| | |

| City | Province | Postal Code |
|---|---|---|
| | | |

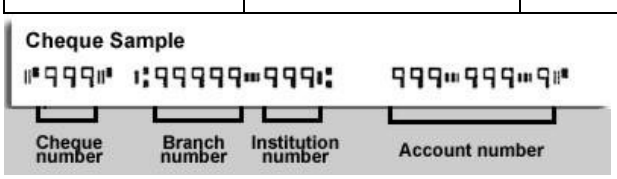
| Primary Phone Number | Secondary Phone Number |
|---|---|
| | |

Email Address

### DIRECT DEPOSIT FOR REIMBURSEMENTS - Mandatory for electronic submission of claims

Please complete below or attach a void cheque for Direct Deposit of Reimbursements (**Mandatory for electronic submission of claims, mobile and web based applications.** You will receive an Explanation of Benefits summary by email with each claim **and** have access to claims and coverage information through the mobile and web based applications).

| Cheque Number | Branch Number | Institution Number | Account Number |
|---|---|---|---|
| | | | |



## Section Two – Tell Us About Your Dependents

| | First Name | Last Name | Gender | Date of Birth | Dependent Status | Dependent of |
|---|---|---|---|---|---|---|
| Spouse | | | | *Month / Day / Year* | ❑ Common Law<br>❑ Married | N/A |
| Child (1) | | | | *Month / Day / Year* | ❑ Total Disability<br>❑ Student | ❑You ❑Spouse<br>❑Both |
| Child (2) | | | | *Month / Day / Year* | ❑ Total Disability<br>❑ Student | ❑You ❑Spouse<br>❑Both |
| Child (3) | | | | *Month / Day / Year* | ❑ Total Disability<br>❑ Student | ❑You ❑Spouse<br>❑Both |
| Child (4) | | | | *Month / Day / Year* | ❑ Total Disability<br>❑ Student | ❑You ❑Spouse<br>❑Both |

.*If you require more space, please use an additional enrollment form.

1. **Over Age Dependent-Student** – If you have dependent children who have reached the first age limit for coverage stipulated in the contract who are still attending school full time, please complete the confirmation of school attendance information below. Coverage for over-age dependents will terminate on August 31st of each year, therefore, the plan member must re-apply if the child re-enrolls in the following school year.

2. **Total Disability**– If you have a dependent child who has a total and permanent physical or mental disability and is totally dependent on the plan member, additional and ongoing information may be required.

| First Name | Last Name | Date Enrolled as a Full-Time Student |
|---|---|---|
| | | *Month / Day / Year* to *Month / Day / Year* |
| Name and Address of Accredited School | | |
| | | |

| First Name | Last Name | Date Enrolled as a Full Time Student |
|---|---|---|
| | | *Month / Day / Year* to *Month / Day / Year* |
| Name and Address of Accredited School | | |
| | | |

## Section Three – Your Coverage

**Does your spouse have a plan?** ❑ Yes (complete below if waiving health and dental. Then continue to Election of Coverage, next page, Section Three, Part B)

❑ No (continue to Election of Coverage, next page, Section Three, Part B)

All benefits under your group insurance plan are mandatory. However, you may waive the health and dental insurance benefits if you have coverage under your spouse's plan.

I understand the terms and conditions of the group insurance plan that is being offered and I waive the following benefits because my spouse carries coverage:

❑ **Waive Health Insurance**

Spouse's Employer:_____Spouse's Employer Phone:_____

Spouse's Insurer Name:_____Spouse's Policy #:_____

Coverage Start Date:_____

❑ **Waive Dental Insurance**

Spouse's Employer:_____Spouse's Employer Phone:_____

Spouse's Insurer Name:_____Spouse's Policy #:_____

Coverage Start Date:_____

If coverage under your spouse's plan is discontinued, you will have a 31-day period in which to submit a notice of change. After this date, your status will be considered as a "Late Applicant" and you and your dependents must submit proof acceptable to Lewer Canada Ltd in order for your application to be reviewed, and as a Late Applicant, coverage may be limited or denied.

## Section Three, Part B – Election of Coverage

**HEALTH CARE (You must choose one.)**

- ❑ Single
- ❑ Family
- ❑ Waive coverage for myself and dependents
- ❑ Waive coverage for my dependents only
- ❑ Coordination of Benefits
- ❑ Couple (Status may not be available)
- ❑ Single Parent (Status may not be available)

**DENTAL CARE (You must choose one.)**

- ❑ Single
- ❑ Family
- ❑ Waive coverage for myself and dependents
- ❑ Waive coverage for my dependents only
- ❑ Coordination of Benefits
- ❑ Couple (Status may not be available)
- ❑ Single Parent (Status may not be available)

**VOLUNTARY BENEFITS (If applicable, through payroll deduction)**

- ❑ Employee Life Insurance; Number of units applied for: _____
- ❑ Employee Accidental Death and Dismemberment; Number of units applied for: _____
- ❑ Employee Other: _____

- ❑ Spouse Life Insurance; Number of units applied for: _____
- ❑ Spouse Accidental Death and Dismemberment; Number of units applied for: _____
- ❑ Spouse Other: _____

## Section Four – Tell Us About Your Beneficiary (ies)

**PRIMARY BENEFICIARY**

| First Name | Last Name | Date of Birth | % | Revocable | Irrevocable | Relationship to employee |
|---|---|---|---|---|---|---|
| | | *Month / Day / Year* | | ❑ | ❑ | |
| | | *Month / Day / Year* | | ❑ | ❑ | |
| | | *Month / Day / Year* | | ❑ | ❑ | |
| | | *Total (must be equal to 100%)* | | | | |

**CONTINGENT BENEFICIARY**

| First Name | Last Name | Date of Birth | % | Revocable | Irrevocable | Relationship to employee |
|---|---|---|---|---|---|---|
| | | *Month / Day / Year* | | ❑ | ❑ | |
| | | *Month / Day / Year* | | ❑ | ❑ | |
| | | *Month / Day / Year* | | ❑ | ❑ | |
| | | *Total (must be equal to 100%)* | | | | |

*If the beneficiary or contingent beneficiary is a minor (under the age of 18), please designate a trustee:* _____

*Relationship of trustee to employee:* _____

Unless otherwise stipulated or not permitted by law, any beneficiary designation is revocable. If a beneficiary is named irrevocably, please note that his/her consent is required for any request that may affect his/her rights, including a change of beneficiary. In Quebec, the designation of the owner's married or civil union spouse as beneficiary is irrevocable, unless otherwise stipulated. The policy does not confer any rights to contingent beneficiaries prior to the death for the primary beneficiaries.

I hereby declare the above designation of my benefits.

**Signature of Employee**_____ Date _____

## Section Five – Declarations and Authorizations

I confirm that the information and answers that I have provided in this document are true and complete and are part of the agreement.

I authorize my employer to withdraw the necessary contributions from my salary.

I authorize Lewer Canada Ltd., Assumption Life and/or Empire Life to deposit all my claim reimbursements to the designated bank account.

I authorize any insurer, reinsurer, physician, health care provider or professional, pharmacy, hospital, clinic, my group insurance administrator, administrator of a government or other fringe benefits program, organization or service provider within the scope of my group insurance plan that holds information pertaining to me or my dependents to collect, use and disclose such records or information with Lewer Canada Ltd., Assumption Life and/or Empire Life for the purposes of determining eligibility to benefits and for plan administration or claims analysis purposes. This information may be of a medical or other nature.

In the event of death, I authorize any beneficiary, heir or executor to provide Lewer Canada Ltd., Assumption Life, Empire Life and/or its reinsurers with all information or authorizations deemed necessary for claims adjudication purposes and for obtaining supporting documentation. I authorize any coroner, police force, or toxicologist that holds my personal information, including any accident and police investigations reports regarding a claims communication of my personal information (other than medical nature) to any private investigator and authorize this private investigator to communicate any information collected regarding me to Lewer Canada Ltd., Assumption Life and/or Empire Life.

This authorization is valid for the purposes of this contract, its modification, its extension or its reinstatement. I acknowledge that any reproduction of this authorization shall be as valid as the original.

I authorize Lewer Canada Ltd., Assumption Life and/or Empire Life to use my personal information in order to send me information on other products and services that might interest me. If not, please check the following: ❑ I do not authorize this use.

I understand that my information is subject to the Lewer Canada, Ltd privacy policy that I can access at www.lewer.ca.

I understand that data will be stored in both the United States and Canada.

I hereby understand that coverage will be effective when approved by the insurers and give consent for underwriting, administration and claims adjudication and allows us to use personally identifiable claim information for predictive modeling and intervention at the individual level.

I certify that I am authorized by my spouse and/or dependents to disclose and receive information about them for the purposes as stated above.

**Signature of Employee**_____ Date _____

## Section Six – To be Completed by the Employer

***PLEASE READ CAREFULLY!*** ***** PLEASE COMPLETE AND SUBMIT THIS ENTIRE FORM TO LEWER CANADA LTD WITHIN 31 DAYS FOLLOWING THE EMPLOYEE'S ELIGIBILITY DATE (eligibility date is the date of permanent full time hire, plus the entire eligibility period required prior to commencement of coverage – See contract for details). APPLICATIONS SUBMITTED DURING THIS ELIGIBILITY PERIOD WILL BE ACCEPTED AS PER UNDERWRITING REQUIREMENTS. APPLICATIONS SUBMITTED AFTER THE ELIGIBILITY PERIOD MAY REQUIRE EVIDENCE OF INSURABILITY FROM THE EMPLOYEE AND/OR DEPENDENTS AND COVERAGE MAY BE LIMITED OR DENIED.*****

| Company Name | | | Policy Number |
|---|---|---|---|
| | | | |
| Mailing Address | | | |
| | | | |
| Main Phone Number | Plan Administrator's Email Address | | |
| | | | |
| Division Number | Class Name or Designation | Occupation | |
| | | | |
| Date of Full Time Hire | Qualifying Period | Benefit Plan Start Date | |
| *Month / Day / Year* | *Begins after (#)*_____*of days* | *Month / Day / Year* | |
| Hours Per Week | Income | | |
| | $ | ❑ Yearly ❑ Monthly ❑ Bi-Weekly ❑ Weekly ❑ Hourly | |

**Signature of Employer**_____ Date