Health Benefits Administration
Seventh-day Adventist Church in Canada
1148 King Street East, Oshawa, ON L1H 1H8
Telephone 1-800-263-7868

Life Insurance, Critical Illness Insurance and Personal Accident Protection Plan

Application for Coverage - Acceptance and approval of this application will provide for the stated benefit in the event of the death of the covered individual. **Parts 1, 2, 3, and 4 of this form *must* be completed.** Please type or print neatly.

Part 1 – General Information

Employee Name _____ Sex M ☐ F ☐

Complete Mailing Address _____ Postal Code _____

Certificate Number _____ Date of Birth _____ | _____ | _____
Day | Month | Year

Employer Name _____ Group # 103582 Your Occupation _____

Spouse Name _____ Sex M ☐ F ☐

Date of Birth _____ | _____ | _____ Do you have eligible dependent children? Y ☐ N ☐
Day | Month | Year

Part 2 – Optional Life Insurance

Must be in multiples of $10,000, $300,000 maximum for each of Employee and Spouse; Child benefit is $15,000. In addition to the Basic Life Insurance provided in the Health Benefits Plan, I would like to purchase the following Optional Life Insurance.
Attached Sun Life Health Statement form must be completed.

Employee Optional Life:
A: Existing Amount of coverage (if applicable) $_____
B: New Amount of coverage requested $_____
C: Total Amount of coverage (A + B) $_____

Spouse Optional Life:
A: Existing Amount of coverage (if applicable) $_____
B: New Amount of coverage requested $_____
C: Total Amount of coverage (A + B) $_____

Child Optional Life:
A: Existing Amount of coverage (if applicable) $_____
B: New Amount of coverage requested $_____
C: Total Amount of coverage (A + B) $_____

☐ I do not wish to apply for Optional Life Insurance



_____ _____
Employee Signature for Optional Life Insurance | Date

Part 3 – Additional Personal Accident Protection Plan Insurance

Must be in multiples of $5,000. Minimum and maximum benefit is $10,000 and $400,000 respectively for each of Employee and Spouse; Child maximum is $25,000. I would like to purchase the following Additional Personal Accident Protection Plan Insurance. ***It is not necessary to complete the attached Sun Life Health Statement for the Additional Personal Accident Protection Plan Insurance.***

Employee Additional Personal Accident Protection Plan Insurance:

A: Existing Amount of coverage (if applicable) $_____
B: New Amount of coverage requested $_____
C: Total Amount of coverage (A + B) $_____

Spouse Additional Personal Accident Protection Plan Insurance:

A: Existing Amount of coverage (if applicable) $_____
B: New Amount of coverage requested $_____
C: Total Amount of coverage (A + B) $_____

Child Additional Personal Accident Protection Plan Insurance:

A: Existing Amount of coverage (if applicable) $_____
B: New Amount of coverage requested $_____
C: Total Amount of coverage (A + B) $_____

☐ I do not wish to apply for Additional Personal Accident Protection Plan Insurance



_____ _____
Employee Signature for Additional Personal Accident Protection Plan Insurance Date

Part 4 – Optional Critical Illness Insurance

Must be in multiples of $10,000. Minimum and maximum benefit is $20,000 and $200,000 respectively for each of Employee and Spouse; Child maximum is $20,000 (Units of $5,000). I would like to purchase the following Optional Critical Illness Insurance. ***Attached Sun Life Health Statement form must be completed. See special offer for exception.***

Employee Optional Critical Illness:

A: Existing Amount of coverage (if applicable) $_____
B: New Amount of coverage requested $_____
C: Total Amount of coverage (A + B) $_____

Spouse Optional Critical Illness:

A: Existing Amount of coverage (if applicable) $_____
B: New Amount of coverage requested $_____
C: Total Amount of coverage (A + B) $_____

Child Optional Critical Illness:

A: Existing Amount of coverage (if applicable) $_____
B: New Amount of coverage requested $_____
C: Total Amount of coverage (A + B) $_____



☐ I do not wish to apply for Optional Critical Illness Insurance



_____ _____
Employee Signature for Optional Critical Illness Insurance Date

Part 4 A – Beneficiary Form (If you do not appoint a beneficiary, the benefit will be payable to the estate.)

As a participating member in the Group Insurance contracts issued to the Seventh-Day Adventist Church in Canada, I hereby designate the following beneficiary or beneficiaries for the various plans in which I participate.

Plan	Last Name of Beneficiary	First Name	Relationship of Beneficiary* to Plan Member
Basic Life Program **All employees must provide a beneficiary**			
Optional Life Program **Employees purchasing Optional Life Program must provide a beneficiary**			
Basic Personal Accident **All employees must provide a beneficiary**			
Optional Personal Accident **Employees purchasing Optional Personal Accident must provide a beneficiary**			

In Quebec, the designation of your spouse as beneficiary is irrevocable unless otherwise specified. If Beneficiary is shown as irrevocable, his/her consent is required to change it.

FOR QUEBEC RESIDENTS ONLY

If spouse is beneficiary, designation is:
☐ Revocable ☐ Irrevocable

Except for an irrevocable designation in Quebec, you may change your beneficiary at any time without the beneficiary's consent.

Dated at_____this_____day of_____in the year _____

_____
SIGNATURE OF LIFE INSURED



*** If beneficiary is under the age of majority, complete the Declaration Appointing Trustee (see below).**

TRUSTEE DESIGNATION *(Not applicable in Quebec*)*

You can appoint a trustee to receive any amount due to any beneficiary under the age of majority.

Trustee's last name_____First name_____

Dated at_____this_____day of_____in the year _____

_____
SIGNATURE OF LIFE INSURED



_____
SIGNATURE OF WITNESS



Part 4 B – Beneficiary Form

I CERTIFY that all the information in this form is complete, current and accurate to the best of my knowledge and belief and that I have authority to release and exchange personal information concerning my spouse and dependents.

On behalf of myself and my dependents, **I CONSENT TO THE RELEASE** of the information provided to my Employer/Policyholder and to my insurance company's employees, agents, reinsurers and service providers for the purpose of underwriting, administration, claims processing and the enrolment of myself and my dependents in my Employer's/Policyholder's group insurance plan. In addition, **I UNDERSTAND** that personal information may be subject to disclosure to those authorized under the applicable laws within or outside of Canada.

I AUTHORIZE my employer to make the required salary deductions for my group insurance plan.



_____
Signature of Plan Member

_____
Date Signed