

Health Benefits Administration Seventh-day Adventist Church in Canada

1148 King Street East, Oshawa, ON L1H 1H8

Telephone 1-800-263-7868 or 905-433-3964 • **Fax** 905-433-3717

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 🛚
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 Day Month Year	Do you have eligible dependent children? Y _ N [
Part 2 – Optional Life Insurance		
	maximum for each of Employee and Spouse; Child bene Health Benefits Plan, I would like to purchase the following m must be completed. \$	
☐ I do not wish to apply for Optional Life I	signature Insurance must be physically hand - signed with a pen!	
Ī	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 Prof A: Existing Amount of coverage (if applicable) B: New Amount of coverage requested C: Total Amount of coverage (A+B)		
Spouse Additional Personal Accident Protect 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 A: Existing Amount of coverage (if applicable) B: New Amount of coverage requested C: Total Amount of coverage (A + B)		signature
☐ I do not wish to apply for Additional Persona	I Accident Protection Plan Insurance	must be physically hand - signed with a pen!
Employ	ee Signature for Additional Personal Accident	Protection Plan Insurance Date
Part 4 – Optional Critical Illness Insurance	e	
Must be in multiples of \$10,000. Minimum and rand Spouse; Child maximum is \$20,000 (Units Insurance. <i>Attached Sun Life Health Statement Statement</i>	of \$5,000). I would like to purchase the	ne following Optional Critical Illness
Employee Optional Critical Illness: A: Existing Amount of coverage (if applicable) B: New Amount of coverage requested	\$ \$	
C: Total Amount of coverage (A + B)	\$	A limited time offer. Must apply within
Spouse Optional Critical Illness: A: Existing Amount of coverage (if applicable) B: New Amount of coverage requested C: Total Amount of coverage (A + B)	\$ \$ \$	31 days of your Health Benefits start date without answering any health questions. Please refer to "Let's"
Child Optional Critical Illness: A: Existing Amount of coverage (if applicable) B: New Amount of coverage requested C: Total Amount of coverage (A + B)	\$ \$ \$	prepare you for whatever life brings" document.
☐ I do not wish to apply for Optional Critical III	ness Insurance	signature must be physically hand - signed with a pen!
Emplo	yee Signature for Optional Critical Illness Insu	rance 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 Quahas, the designation of	version and the medicines in	FOR QUEBEC RESIDENTS ONLY			
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.		If spouse is beneficiary, designation is: ☐ Revocable ☐ Irrevocable			
Except for an irrevocable designati	on in Quebec, you may change your benefic	ciary at any time withou	ut the beneficiary's consent.		
Dated at	thisday of	in the ye	ear		
signature must be physically hand - signed with a pen!					
* If beneficiary is under the age of majority, complete the Declaration Appointing Trustee (see below).					
TRUSTEE DESIGNATION (Not appl	icable in Quebec*)				
You can appoint a trustee to receive any amount due to any beneficiary under the age of majority. Trustee's last name					
Dated atSIGNATURE OF LIFE INSURE	thisday of	in the ye	ear		
SIGNATURE OF LIFE INSURE		SIGNATU	INL OF WITINESS		

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)	
must be physically	
must be physicing	
hand - signed	
with a pen!	

Signature of Plan Member Date Signed