EMPLOYEE GROUP BENEFITS APPLICATION/CHANGE FORM

Internal use only

Alberta Municipalities Strength In Members

Instructions

Employee must complete all sections except section 6 which the employer must complete. Print clearly in dark ink and return this signed original form to your employer.

Change Effective Date (yyyy-mm-dd):

1 *Personal Information*

First name	Last name	Date of birth *(yyyy-mm-dd)*	Gender ◯ **Male** ◯ **Female**
Street address	City	Province	Postal code
Home phone	Mobile phone	Work phone	
Home email	Work email		

2 *Dependent Information*

List all eligible dependents, even if they have coverage elsewhere. If there is not enough room to list all dependents, attach an additional sheet.

2A *Spouse*

First name	Last name	Date of birth *(yyyy-mm-dd)*	Gender ◯ **Male** ◯ **Female**
Marital status ◯ **Married** ◯ **Common law** ◯ **Divorced or separated**		If common law, provide cohabitation start date *(yyyy-mm-dd)*	

2B *Dependent Children*

An overage student is a dependent child age __ or older but under __ (see your policy booklet), who is a full-time student attending an accredited educational institution, as long as the child is not married (or in a formal union) and is entirely dependent on you for financial support (see section 2C). Permanently disabled dependents may be eligible for coverage beyond the termination age and require additional forms to be completed (contact your administrator).

First name	Last name	Date of birth *(yyyy-mm-dd)*	Gender	Overage student?	Permanently disabled?
			☐ **Male** ☐ **Female**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
			☐ **Male** ☐ **Female**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
			☐ **Male** ☐ **Female**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
			☐ **Male** ☐ **Female**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
			☐ **Male** ☐ **Female**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**

2C *Overage Dependent Child School Information*

For each overage child in school, you must provide the following school enrollment information for the accredited institution they are attending full-time.

Dependent child name	School name	School location *(city, prov.)*	Current semester begins *(yyyy-mm-dd)*	Current semester ends *(yyyy-mm-dd)*

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3 *Beneficiary Designation*

Complete in ink only and do not use correction fluid as this is a legal document. Initial any changes or corrections. This beneficiary designation applies to all benefits where a beneficiary is payable (such as Life, Disability or Critical Illness) unless otherwise specified. In the event you list more than one beneficiary, ensure the total share percentage you allocate adds up to 100%. If there is not enough room to list all beneficiaries, attach an additional sheet. If you do not designate a beneficiary, proceeds will be paid to your estate. Policy proceeds cannot be paid to a minor or an individual lacking legal capacity. If you wish to name a beneficiary that is a minor, or an individual that lacks legal capacity, it is strongly advised that you consult a legal advisor before doing so. Should you wish to use this form to name a trustee, complete section 3D and ensure that the trustee you have selected has been advised.

For Quebec Residents Only

Where Quebec law applies and you have designated your married spouse or civil union spouse as beneficiary, the designation will be irrevocable unless you check the box marked "Revocable", below. For reference these terms may be summarized as follows:

- Revocable - Designation can be changed without the beneficiary's consent.
- Irrevocable - Designation cannot be changed without the beneficiary's consent, unless the beneficiary is deceased. If you designate a minor as an irrevocable beneficiary, the designation cannot be changed until the person reaches the age of majority (as defined by their province of residence).

3A *Primary Beneficiary Designation*

Beneficiary for Basic Life

First name	Last name	Date of birth (yyyy-mm-dd) If under 18 complete section 3D	Relationship to employee	Designation QC residents only	Share %
				☐ Revocable ☐ Irrevocable	
				☐ Revocable ☐ Irrevocable	
				☐ Revocable ☐ Irrevocable	
				☐ Revocable ☐ Irrevocable	
				☐ Revocable ☐ Irrevocable	

Share total must equal 100%

Beneficiary for Accidental Death & Dismemberment

First Name	Last Name	Date of birth (yyyy-mm-dd) If under 18 complete section 3D	Relationship to employee	Designation QC residents only	Share %
				☐ Revocable ☐ Irrevocable	
				☐ Revocable ☐ Irrevocable	
				☐ Revocable ☐ Irrevocable	
				☐ Revocable ☐ Irrevocable	
				☐ Revocable ☐ Irrevocable	

Share total must equal 100%

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3B *Contingent Beneficiary Designation (optional)*

If there are no surviving primary beneficiaries at the time of your death, the following contingent beneficiaries will receive the proceeds. If there are no surviving primary or contingent beneficiaries, the proceeds will be paid to your estate.

Contingent Beneficiary for Basic Life

First name	Last name	Date of birth *(yyyy-mm-dd)* *If under 18 complete section 3D*	Relationship to employee	Designation *QC residents only*	Share %
				☐ **Revocable** ☐ **Irrevocable**	
				☐ **Revocable** ☐ **Irrevocable**	
				☐ **Revocable** ☐ **Irrevocable**	
				☐ **Revocable** ☐ **Irrevocable**	

Share total must equal 100%

Contingent Beneficiary for Accidental Death & Dismemberment

First Name	Last Name	Date of birth (yyyy-mm-dd) If under 18 complete section 3D	Relationship to employee	Designation QC residents only	Share %
				☐ **Revocable** ☐ **Irrevocable**	
				☐ **Revocable** ☐ **Irrevocable**	
				☐ **Revocable** ☐ **Irrevocable**	
				☐ **Revocable** ☐ **Irrevocable**	
				☐ **Revocable** ☐ **Irrevocable**	

Share total must equal 100%

3C *Out of Country Beneficiary Contact Information (optional)*

If any beneficiaries reside outside of Canada please provide contact information for that beneficiary.

Beneficiary name	Country	Address	Phone number

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3 *Beneficiary Designation Continued*

3D *Trustees for Minor Beneficiaries*

If you have already, in any document, made a Trustee/Administrator appointment which might apply, we advise that you consult first with your legal advisor before completing this Trustee section. It is also recommended that you get approval from your chosen Trustee prior to naming them herein.

I hereby appoint the following Trustee, if designated herein, to receive and to hold in trust, on behalf of any beneficiary, money payable to the beneficiary under this group benefits plan where, at the time payment is to be made, the beneficiary is a minor or otherwise lacks legal capacity. Any such payment, to its extent, will release the underwriting carrier from further liability. The Trustee shall act prudently and may use the money, including any returns on it or investments made, for the education and/or maintenance of the beneficiary. The trust will terminate once the beneficiary is of the age of majority and has legal capacity. At that time, the Trustee shall deliver to the beneficiary all assets held in trust.

In Quebec, there may be issues with respect to the appointment of a trustee, you should consult your legal advisor before appointing a trustee.

Minor beneficiary name(s)	Trustee first name	Trustee last name	Trustee relationship to employee

4 *Alternate Coverage (optional)*

If eligible, your participation under this group plan is mandatory. However, should you and/or your eligible dependents be covered under a qualifying alternate plan, such as a spouse's group plan, an exemption of benefits and/or coordination of benefits may be applicable. If there is not enough room to list all alternate plans, attach an additional sheet.

4A *Coordinate Benefits*

If you and/or your eligible dependents are covered under another group plan you can choose to coordinate expenses with an alternate group plan. Any combined reimbursement will not exceed 100% of the total eligible claimed amount.

Coordinate ☐ **Health** ☐ **Dental**

Alternate plan carrier	Policy # / Certificate #	Effective date *(yyyy-mm-dd)*	Plan covers myself
			☐ **Yes** ☐ **No**

Plan covers dependents ☐ **All dependents** ☐ **Select dependents** ☐ **None**

If only select dependents are covered, list them

4B *Exempt Benefits*

If you and your eligible dependents are covered under another group plan you can choose to exempt out of certain coverages under this plan.

Exempt Dependent(s) Only

Some or all of my eligible dependents are covered under another qualifying group plan and do not wish to be covered by this plan.

Exempt dependents from ☐ **Health** ☐ **Dental**

Alternate plan carrier	Policy # / Certificate #	Effective date *(yyyy-mm-dd)*	Plan covers myself
			☐ **Yes** ☐ **No**

Plan covers dependents ☐ **All dependents** ☐ **Select dependents** ☐ **None**

If only select dependents are covered, list them

Exempt Entirely

All of my eligible dependents and I are covered under another qualifying group plan and do not wish to be covered by this plan.

Exempt entirely from ☐ **Health** ☐ **Dental**

Alternate plan carrier	Policy # / Certificate #	Effective date *(yyyy-mm-dd)*

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5 *Employee Authorization*

Your Group Benefits Plan Administration Provider is: AMSC Insurance Services Ltd. (the "Administrator").

APPLICATION TO PLAN: I agree and consent to the Administrator being retained as the plan administration provider of my group life and benefits plan (the "Plan"). I hereby apply for group benefit coverage for which I am or may become eligible under the Plan. I hereby revoke any previous beneficiary designations in relation to my foregoing coverage(s) and designate the person(s) named above in Section 4. I authorize the Administrator to act on my behalf as liaison between me and the underwriting carrier(s) and/or benefit product provider(s) supporting the Plan from time to time with regard to any issue or concern that may arise from any claim or policy issue. When applicable, I authorize my plan sponsor to deduct from my pay and to remit to the Administrator the member contributions that may be required under the Plan on behalf of the insurance carrier(s) and benefit product provider(s) then supporting the Plan.

I certify that the information given by me in this form is true, correct and complete to the best of my knowledge, and I agree that a copy or electronic version of this authorization shall be as valid as the original.

PRIVATE INFORMATION CONSENT: I authorize the Administrator to collect, use and disclose personal information, including health claims experience information derived by my usage of the Plan, for the purposes of determining, maintaining, and assisting with: eligibility for coverage, plan sponsor renewal rates, claims investigations, plan underwriting and quoting, plan administration, producing plan usage analytics and reporting, claims management, and maintaining records concerning your relationship with the Administrator, PROVIDED THAT access to my personal information will be limited to Administrator employees who require such information in the performance of their jobs, persons to whom I have granted access, and persons authorized by law. I acknowledge that my personal information will only be collected from and/or released to a third party (healthcare professional, (re)insurer or product provider, agent of record, plan sponsor, and/or my employer) only when needed for a purpose stated above, and otherwise will be kept in strict confidence. I acknowledge that my personal information may be included in aggregated analyses, reports, and analytics of Plan usage, and that my personal information shall not be made identifiable to the users thereof. I confirm that I am authorized by my spouse and dependents to consent to the Administrator's collection, use, maintenance, exchanging, and disclosure of their personal information for the purposes stated in this paragraph. I understand why I have been asked to disclose this information and am aware of the risks and benefits of consenting. I understand that I have the right to request access to the personal information in my file and to correct any inaccurate information. This consent is effective as of the date of this enrollment form and my consent will be valid so long as my Plan is administered by the Administrator, unless expressly revoked by me at an earlier time. I understand that I can revoke this consent at any time in writing; and that, if consent is withheld or revoked, my Plan coverage may be denied or rescinded.

Return this signed original form to your employer

Employee first & last name	Date signed *(yyyy-mm-dd)*	Employee signature
		X

More detailed information concerning how and why the Administrator collects, uses and discloses my personal information is available at:
www.abmunis.ca/contact-us

6 *Employment Information (to be completed by the employer)*

Section 6 to be completed by the employer

Organization name	Division	Class	Change Effective Date *(yyyy-mm-dd)*

Enrollment type	Employment/re-hire date *(yyyy-mm-dd)*	Permanent position date *(yyyy-mm-dd)* (optional)
☐ **Enrollment** ☐ **Reinstatement** ☐ **Change**		

Employment type	Job title	Province of employment	Hours per week
☐ **Full time** ☐ **Part time**			

Salary basis	Salary *(exclude commissions)*	Annual commissions *(2 year average)*	Annual Bonus *(2 year average)*
☐ **Annual** ☐ **Monthly** ☐ **Semi-monthly** ☐ **Bi-weekly** ☐ **Weekly** ☐ **Hourly**			

6A *Enrollment Exceptions*

Enrollment exceptions *(optional)*	New class *(changing the default class may require insurance carrier approval)*
☐ **Waive the waiting period, and/or** ☐ **Change the default class**	

Explanation for any exception

6B *Employer Authorization*

Employer first & last name	Date signed by employer (yyyy-mm-dd)	Employer signature
		X