

New Application Reinstatement of Coverage

PLAN SPONSOR / EMPLOYER NAME CUPE Local 403			GROUP NUMBER 28059		
1. EMPLOYEE INFORMATION			Tell us about yourself		
LAST NAME		FIRST NAME		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	
				DATE OF BIRTH Month Day Year	
SOCIAL INSURANCE NUMBER		LANGUAGE <input type="checkbox"/> ENGLISH <input type="checkbox"/> FRENCH		MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> COMMON-LAW <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOW	
PHONE () -		STATUS INDIAN <input type="checkbox"/> YES <input type="checkbox"/> NO			
ADDRESS (for mailing purposes) NUMBER AND STREET		APT.	CITY	PROVINCE	POSTAL CODE

If your application is received more than 31 days after the effective date of coverage, or (if applicable) the amount of the life insurance and/or long term disability benefit is greater than the maximum amount permitted without evidence of insurability, your application must be accompanied by an **'Evidence of Insurability'** form. For further information, please contact the Plan Administrator.

I hereby apply for the benefits for which I am or may become eligible under the group plan ("Benefit Plan") established by my employer. In order to participate in the benefit program established by my employer and to apply for the benefits for which I or my spouse or dependents may be eligible. I understand that my social insurance number is required for identification purposes and for income tax purposes. I consent to the use of my social insurance number for those purposes and also consent to the disclosure of my social insurance number to third parties who require my social insurance number for the purpose of adjudicating claims and maintaining the benefit program. I also consent to the use and disclosure of other personal information about me or my spouse and dependents to third parties, such as the administrator of the plan, the insurer and any professional advisors or consultants when that personal information is needed for the purpose of adjudicating claims or in order to maintain the benefit program. I authorize the release of statistical information (excluding specific medical details) regarding submitted claims (whether submitted on my behalf or on behalf of my spouse or dependents) to my employer or to other third parties such as professional advisors or consultants. I also direct and authorize my employer to deduct from my salary or wages any required contributions which I must make personally in order to become eligible for and remain a member of the benefit program. I certify that the information provided on this form is true and accurate. I understand that if any statement made herein is incomplete or false, any coverage granted may be voided in whole or in part.

SIGNATURE OF EMPLOYEE	DATE	Month Day Year

This Section is for Employer use only

EMPLOYER STATEMENT						
DIVISION		UNIT / CLASS	ANNUAL EARNINGS \$		HOURS PER WEEK	OCCUPATION
DATE OF FULL-TIME PERMANENT HIRE Month Day Year		IF A REHIRE, PROVIDE RE-HIRE DATE & Month Day Year		DATE PREVIOUS EMPLOYMENT ENDED Month Day Year		EFFECTIVE DATE OF COVERAGE Month Day Year
AUTHORIZED SIGNATURE			TITLE		DATE Month Day Year	

Please submit form to your employer