SSQ Financial Group

ENROLMENT or RE-ENROLMENT APPLICATION FORM

❑ New Application ❑ Reinstatement of Coverage

PLAN SPONSOR / EMPLOYER NAME	GROUP NUMBER
CUPE Local 403	13JT0

1. EMPLOYEE INFORMATION — Tell us about yourself

LAST NAME	FIRST NAME	GENDER	DATE OF BIRTH
		❑ Male ❑ Female	Month Day Year

SOCIAL INSURANCE NUMBER	LANGUAGE	MARITAL STATUS
	❑ ENGLISH ❑ FRENCH	❑ SINGLE ❑ MARRIED ❑ COMMON-LAW ❑ DIVORCED ❑ WIDOW
PHONE ( ) -		STATUS INDIAN ❑ YES ❑ 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	IF A REHIRE, PROVIDE RE-HIRE DATE &	DATE PREVIOUS EMPLOYMENT ENDED	EFFECTIVE DATE OF COVERAGE
Month Day Year	Month Day Year	Month Day Year	Month Day Year

AUTHORIZED SIGNATURE	TITLE	DATE
		Month Day Year

Please submit form to your employer