



APPLICATION FOR GROUP BENEFIT COVERAGE

Mandatory Participation required for all eligible employees

- Instructions:** 1) Please print all information clearly in *blue* or *black* ink. **PLEASE WRITE LEGIBLY.**
2) Employer to forward **original** to Benefit Administration Office and keep second copy.

1. Policyholder Section - To be completed by **Benefit Representative**. Select the appropriate Benefit Class.

Class 1: Permanent Employees Class 2: 1 year – Contract Employees Class 4: Priests

Class 8: All Other Employees (non-salary, religious) Class 100: Pension *only* for PT employee's under 20 hrs/week but earn no less than 35% of CCRA's, Years maximum Pensionable Earnings (YMPE). Must have been employed with the employer for 2 consecutive years.

School/Parish (ER): _____ Division/ER No.: _____

Employee ID number: _____ SIN: _____
(to be assigned by the Benefit Administration Office)

Date of employment: Month _____ Day _____ Year _____

Effective date of coverage: Month _____ Day _____ Year _____

Probation Period Applied?
If "yes", how long?
_____ months
(Teachers are not subject to a probation period)

Late Applicant? Yes **OR** No | Identified as: Catholic **OR** Non-Catholic

Occupation: _____ | Gross Annual Earnings: \$ _____ (must be reflected as an annual salary)

No. of **hours** worked per week: _____
(minimum 20 hour work-week requirement for coverage of employer group benefits)

Income earned/paid within the month of the Effective date of coverage

\$ _____ (This is only applicable to those employees who are insured *after* the 1st calendar day of the month AND will be contributing to Pension)

No. of **days** worked per week: _____

No. of **weeks** worked per year : _____ (ie: 43, 48, 52 - For the purpose of GWL disability the minimum Weeks Worked Per Year is 43)

2. Employee Information - To be completed by **Employee**.

Employee name (print): _____
(First Name) (Middle Initial) (Last Name)

Gender: Male Female Date of birth: Month _____ Day _____ Year _____

Mailing address: _____

City: _____ Province: _____ Postal Code: _____

Phone Number: _____ Cellular Phone Number: _____

Email Address: _____

Do you have a spouse (legally married)? Yes No

Do you have dependent children, including full-time students or disabled adults? Yes No

3. Beneficiary Designation - To be completed by those Employees who are eligible for the Life Insurance benefit. **CLASSES 1, 2, AND 4 ONLY**

A beneficiary must be designated for your Life Insurance benefit, if applicable. Your beneficiary(s) are listed as **Revocable**, and can be changed at any time.

Last Name	First Name	Relationship	Distribution %	Gender	Minor
				<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
Total 100%					

Contingent beneficiary(ies) – If all of the above beneficiaries die before me, the Life benefit set out in the group policy is to be paid to:

Last Name	First Name	Relationship	Distribution %	Gender	Minor
				<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
Total 100%					

Trustee Appointment – Please complete the trustee appointment section if any of the primary or contingent beneficiaries are minors or otherwise lack legal capacity to receive the proceeds.

Full Name of Trustee (Last Name, First Name)	Trustee for (indicate the beneficiary name)	Relationship of trustee to the employee/plan member

4. Registered Pension Plan (RPP) – To be completed by eligible Benefit Class 1, 2, 4 and 100 Employee's only.

NOTE: It is not mandatory to enroll in the Registered Pension Plan; however, once you have enrolled, you CANNOT opt-out.

No, at this time I choose to opt-out of the RPP program; or

Yes, I would like to enroll in the RPP program. I understand that while employed, I cannot withdraw from or terminate my RPP contributions. My Employer-matched contribution level will be (choose one):

3% **OR** 7%

My **Voluntary** Pension contribution will be: \$ _____ per month (Vol. pension contributions are **not** matched by the ER)

5. Refusal of Benefits - To be completed by Employee. Important: Extended Health and/or Dental benefits are the **only** benefits that can be refused providing you and/or your dependents are covered by duplicate group benefits through your spouse's employer.

I understand the plan of group benefits offered to me, but **decline** to participate in: **(Employee MUST complete this section if they want to waive the extended health and/or dental. Spouse's plan MUST be provided. If the information is NOT provided, your Extended Health and/or Dental coverage will NOT be waived.)**

Extended Health benefits for: myself and my dependents my dependents only

Dental benefits for: myself and my dependents my dependents only

Spouse's Insurance carrier _____ Their policy number: _____

6. Dependent Information – To be completed by Employee if there is a Family Extended Health and/or Dental benefit.

Spouse's Information (please print):

Last Name _____ First Name _____ Middle Initial _____

Date of Birth: Month _____ Day _____ Year _____

Gender: Male Female

List benefits covered through your spouse's employer plan:

Extended Health Benefits		Dental Benefits	
<input type="checkbox"/> Single	<input type="checkbox"/> Family	<input type="checkbox"/> Single	<input type="checkbox"/> Family
<input type="checkbox"/> Waived	<input type="checkbox"/> None	<input type="checkbox"/> Waived	<input type="checkbox"/> None

Where applicable, benefit payments will be coordinated between this plan & your spouse's.

Dependent Children Information:

Last Name _____ First Name _____ Middle Initial _____

Last Name _____ First Name _____ Middle Initial _____

Last Name _____ First Name _____ Middle Initial _____

Last Name _____ First Name _____ Middle Initial _____

Last Name _____ First Name _____ Middle Initial _____

Date of Birth:
Month /Day/ Year

Gender
M F

Post Disabled
Secondary Dependent
Student? Yes

Indicate post-secondary school the dependent student(s) is attending: _____

7. Authorizations and Declarations - I hereby apply for coverage under the group benefits plan issued by Great-West Life. I authorize:

- My employer to deduct from my pay and remit to Great-West Life the plan member contributions required under the plan, if applicable;
- Great-West Life to use my social insurance number for tax reporting purposes and as an identification number where it is required in the administration of the plan;
- Great-West Life, any healthcare provider, my Benefit Representative at the local level, the Benefit Administration Office, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life to exchange personal information, when necessary to determine my eligibility for coverage and to administer the plan.

If applying for coverage for my spouse and/or dependents, I confirm that I am authorized to act on their behalf. I agree that a photocopy or electronic copy of this Authorizations and Declarations section is as valid as the original.

I certify that the information given is true, correct and complete to the best of my knowledge.

Employee signature: _____ Date: _____

➤ Employer signature: _____ Date: _____

(Received by CISVA – Benefit Administration Office: _____)