

GROUP APPLICATION FOR EMPLOYEE/SPOUSAL OPTIONAL LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Throughout this application, "Empire Life" means The Empire Life Insurance Company.

Group number	Division number	Certificate number
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1. EMPLOYEE INFORMATION

First name	Initial	Last name
Date of birth (dd/mmm/yy)	Province of residence	<input type="radio"/> Smoker <input type="radio"/> Non Smoker

TO BE COMPLETED FOR EMPLOYEE OPTIONAL INSURANCE:

I hereby apply for \$ _____ of Employee Optional Life Insurance which will be subject to medical underwriting.

I understand that this coverage will not be in effect until medically approved by Empire Life.

Include Employee Optional Accidental Death & Dismemberment Benefit.

The amount of the Employee Optional Accidental Death & Dismemberment benefit will equal the Employee Optional Life Insurance amount and will be effective only with the medical underwriting approval of the Employee Optional Life Insurance.

2. BENEFICIARY DESIGNATION

Irrevocable/Revocable designations: A minor irrevocable beneficiary cannot consent to a change of beneficiary and a parent or guardian may not sign on behalf of a minor child for this purpose. All beneficiaries are assumed revocable unless you check the irrevocable box below, except in Quebec. In Quebec, if a married or civil union spouse is named beneficiary, the designation is irrevocable unless you check the revocable box below.

Minors: Outside Quebec, you should name a Trustee to receive the benefits while the beneficiary is still a minor. In Quebec, the benefits will be paid to the Tutor(s) unless you have established a formal Trust.

Multiple beneficiaries: Percentages for all beneficiaries must total 100%. If you name more than one beneficiary and do not indicate a share percentage, the benefits will be divided equally among all surviving beneficiaries. If more space is required, attach a hand-written letter including your signature.

Beneficiary

Name (First, Middle, Last)	Relationship	Share %	<input type="radio"/> Revocable <input type="radio"/> Irrevocable
Date of birth (if minor) (dd/mmm/yy)	Trustee name		
Name (First, Middle, Last)	Relationship	Share %	<input type="radio"/> Revocable <input type="radio"/> Irrevocable
Date of birth (if minor) (dd/mmm/yy)	Trustee name		

3. SPOUSAL INFORMATION

First name	Initial	Last name
Date of birth (dd/mmm/yy)	Province of residence	<input type="radio"/> Smoker <input type="radio"/> Non Smoker

TO BE COMPLETED FOR SPOUSAL OPTIONAL INSURANCE:

On behalf of my Spouse, I hereby apply for \$ _____ of Spousal Optional Life Insurance which will be subject to medical underwriting. My Spouse understands that this coverage will not be in effect until medically approved by Empire Life and that the designated beneficiary must be myself.

Include Spousal Optional Accidental Death & Dismemberment Benefit.

The amount of the Spousal Optional Accidental Death & Dismemberment benefit will equal the Spousal Optional Life Insurance amount and will be effective only with the medical underwriting approval of the Spousal Optional Life Insurance.

4. DECLARATION AND AUTHORIZATION

I understand that:

- the above personal information concerning me and my dependants is being collected by The Empire Life Insurance Company (Empire Life) for the purpose of assessing the risk on a continuing basis and considering whether to issue or renew a group policy of insurance under which I might be or become insured, determining the premium payable for such insurance, assessing my eligibility for coverage and the nature and amounts of such coverage, and assessing any claim made by me, my dependants or beneficiaries;
- this information will be maintained in a file by Empire Life and that only Empire Life employees, agents, representatives, and reinsurers (or any other person I may authorize) will have access to the file when necessary for achieving the purposes of the file. I also understand that I am entitled to consult the file and, when applicable, have it corrected, and that I can exercise this right by contacting the Chief Privacy Officer of Empire Life, at 259 King St. East, Kingston, Ontario K7L 3A8; and
- Empire Life may use third party service providers located outside of Canada to process and store my personal information. I may access the most recent Privacy Policy of Empire Life on their Web site at www.empire.ca.

I authorize:

- Empire Life, its employees, agents, and representatives to collect and use this information for these purposes and to disclose this information to health care providers, other insurance companies or benefit service providers, reinsurers and third-party service providers insofar as such disclosure is required in order to achieve these purposes;
- the Policyholder/plan administrator to disclose personal information concerning me and my dependants to Empire Life in order to update my personal information as required for achieving the purposes of the file;
- Empire Life to release to the Policyholder/plan administrator and agent of record any group statistical information that may include information concerning claims paid on my behalf or on behalf of my eligible dependants (other than specific details relating to medical condition(s)) for the purpose of negotiating policy renewals, premiums and benefits management; and
- the collection, use and disclosure of the personal information for my dependants, if applicable, and confirm that I am authorized to act on their behalf.

I declare:

- that the above answers and statements are full, complete and true, and I agree and understand that these answers are material to the risk and form part of the application and consideration for the insurance applied for.

I hereby apply for benefits for which I am or may become eligible, and authorize payroll deductions, if required.

A photocopy or electronic copy of this application form and authorization will be as valid as the original.

Employee Signature

X

Date signed (dd/mmm/yy)

Spouse/common-law partner Signature

X

Date signed (dd/mmm/yy)

5. TO BE COMPLETED BY EMPLOYER

Name of Employer

Class

Department

Payroll number

Signature of Authorized Official

X

Date (dd/mmm/yy)