GROUP ENROLMENT FORM

Throughout this form "Empire Life" means The Empire Life Insurance Company.

Reset Form

1. EMPLOYMENT INFORMATION (TO BE COMPLETED BY THE PLAN ADMINISTRATOR)

Name of Employer/Division	Group number	Division	Certificate/payroll number

Employee first name	Last name	Date of birth (dd/mmm/yy)

Departmental code (max 5 numbers)	Occupation

Date of hire (dd/mmm/yy)	Number of hours/week	Class	Effective date of coverage (dd/mmm/yy)

Income details	**Amount**	**Indicate if salary amount is hourly, weekly, bi-weekly or annual**
Rate of pay		◯ Hourly
Salary		◯ Weekly ◯ Bi-weekly ◯ Monthly ◯ Annual ◯ Other _____
Bonus		◯ Weekly ◯ Bi-weekly ◯ Monthly ◯ Annual ◯ Other _____
Commission		◯ Weekly ◯ Bi-weekly ◯ Monthly ◯ Annual ◯ Other _____

Signature of Employer X	Date signed (dd/mmm/yy)

2. EMPLOYEE INFORMATION (TO BE COMPLETED BY THE EMPLOYEE)

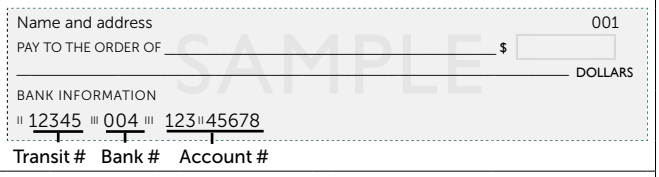
Empire Life may use your email address and/or phone number to contact you for administrative purposes.

◯ Male ◯ Female	Province of residence	Language preference ◯ English ◯ French	Marital status ◯ married ◯ single ◯ common-law

Email address	Phone number	Do you have a provincial health card? (e.g. OHIP, MSP, RAMQ) ◯ yes ◯ no

Claim payments: ◯ **Deposit my Health, Dental and HCSA claim payments electronically to my bank account.**
Please attach a personalized void cheque in the name of the Employee or complete the banking information below:

Bank name		
Transit number	Bank number	Account number



Spouse/Child Information – Please list spouse and all children. If more space is required, attach a separate sheet.

First name	Last name	Relationship (spouse, child)	Date of birth (dd/mmm/yy)	Gender (M/F)	Disabled child*	Full-time student age 22 or older**	Dependant has provincial health card?
					◯ yes	◯ yes	◯ yes
					◯ yes	◯ yes	◯ yes
					◯ yes	◯ yes	◯ yes
					◯ yes	◯ yes	◯ yes

*Complete Disabled Child Dependant Form and submit with Group Enrolment Form.
Complete student information below – Note: **The student must be attending an accredited school, on a full time basis. If more than one student, attach a separate sheet.

First name	Last name	Term start date (dd/mmm/yy)	Term end date (dd/mmm/yy)

Post-secondary school name	If outside Canada or U.S., provide country name and departure date (dd/mmm/yy)

Empire Life

3. WAIVER OR COORDINATION OF BENEFITS

Understanding your choice

- I acknowledge that I have been offered the benefits of my Employer's Group Insurance Plan with The Empire Life Insurance Company and benefits provided by this Plan have been fully explained to me.
- I am forfeiting (as indicated below) all my rights and privileges in respect to such benefits.
- I understand that if I apply for refused/waived coverage in the future, I may be required to provide evidence of insurability at my own expense.
- **If waiver is not selected, family coverage will be applied.**

Do you or any other member of your family have extended health or dental benefits with another plan? ◯ **yes** ◯ **no**
If yes, specify if other coverage is ◯ single coverage ◯ family coverage

Waiver of benefits

If you or your dependants are presently covered for extended health and/or dental benefits under another plan, you may waive such benefits under this contract by selecting the applicable box for each benefit:

◯ I waive coverage for myself and my dependants under: ◯ Extended Health ◯ Dental
◯ I waive coverage for my dependants only under: ◯ Extended Health ◯ Dental

Name of other Insurer _____

Coordination of benefits

I wish to coordinate benefits coverage with my spouse's carrier **and** family coverage with Empire Life under: ◯ Extended Health ◯ Dental

Total Refusal of ALL Benefits (non-mandatory plans only)

◯ I waive all coverage for me and my dependants

4. BENEFICIARY DESIGNATION (to be used only for benefits payable upon death of Insured Employee)

Minors: Death benefits will not be paid directly to a minor beneficiary. Outside Quebec, you should name a trustee for a minor beneficiary and any death benefits due to the beneficiary, while a minor, will be paid to the trustee on their behalf. In Quebec, death benefits due to a beneficiary, while a minor, will be paid to the their parent(s) or legal guardian unless you have established a formal trust. After the beneficiary reaches the age of majority, any death benefits due to the beneficiary will be paid directly to the beneficiary unless you have established a formal trust and such trust is still in effect at the time the death benefit is due.

Primary Designations:

- If a beneficiary is not named, the death benefit will be paid to the Estate of the Employee.
- Percentages for all primary beneficiaries must total 100%.
- If you name more than one beneficiary and do not indicate a share percentage, the death benefits will be divided equally among all surviving beneficiaries.
- You may change this beneficiary designation at any time upon written notice to Empire Life.
- If you wish to make the beneficiary designation irrevocable (meaning you can not change the designation or make changes to your coverage under the plan without the written consent of the beneficiary), please complete the Beneficiary Designation and Authorization form.

Note: 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 circle marked "revocable" below.

I hereby make the beneficiary designation: ◯ revocable - I may change this beneficiary designation at any time.

Primary Beneficiary(ies)

First name	Middle initial	Last name	Relationship	
Date of birth (if minor) (dd/mmm/yy)		Trustee name (required if beneficiary is a minor)		Share (%)
First name	Middle initial	Last name	Relationship	
Date of birth (if minor) (dd/mmm/yy)		Trustee name (required if beneficiary is a minor)		Share (%)

Contingent Beneficiary(ies)

You may wish to designate a contingent beneficiary(ies) to receive any proceeds under this group policy, if all of the primary beneficiaries named, should die before you. Should there not be any surviving beneficiaries at the time of your death, the proceeds will be paid to your Estate. Percentages for all contingent beneficiaries must total 100%.

First name	Middle initial	Last name	Relationship	
Date of birth (if minor) (dd/mmm/yy)		Trustee name (required if beneficiary is a minor)		Share (%)
First name	Middle initial	Last name	Relationship	
Date of birth (if minor) (dd/mmm/yy)		Trustee name (required if beneficiary is a minor)		Share (%)

5. DECLARATION AND AUTHORIZATION

Collection, Use and Access to My Personal Information

I am applying for group benefits coverage with The Empire Life Insurance Company ("Empire Life") and understand that Empire Life needs personal information about me, my spouse and my children (collectively "Dependants"), if applicable, relevant to this application and/or the administration of the group benefits plan ("Personal Information").

If I am applying for coverage for my Dependants:

- I confirm that I am authorized by my Dependants to disclose and receive their Personal Information, to act on behalf of my Dependants and to consent to this authorization on their behalf in relation to their personal infomation;
- I understand that the group benefits coverage is provided through me as the employee plan member and that Empire Life may exchange Personal Information with me and/or my Dependants.

Collection:

I authorize Empire Life and my employer to collect Personal Information from any person or organization that has information relevant to this application and/or the group benefits plan.

I authorize the following persons or organizations that have Personal Information to disclose such information to Empire Life:

- my employer and the group plan administrator;
- my employer's insurance broker and/or advisor (to the extent permitted by my employer);
- my doctor and other health professionals and practitioners (e.g. pharmacists, dentists);
- hospitals, clinics, social service agencies and other similar agencies that have provided services to me;
- professional regulatory bodies (e.g. College of Pharmacists);
- investigative and governmental agencies (e.g. Canada Revenue Agency);
- industry drug pooling entity (e.g. Canadian Drug Insurance Pooling Corporation);
- other insurance companies with which I have or have had coverage; and
- third party service providers that provide services related to the benefit plan (e.g. payroll, enrolment, claims handling services, travel emergency assistance benefits providers, paramedical service providers).

I also authorize the collection of Personal Information by third party service providers for purposes of assessing and administrating claims made by me, my Dependants, or my beneficiary(ies).

Use:

I authorize Empire Life to keep the Personal Information on file and use it for the following purposes:

- to assess the application;
- to assess the risk on a continuing basis and consider whether to issue or renew a group policy of insurance under which I might
- be or become insured;
- to determine the premium payable for such insurance;
- to assess eligibility for coverage and the nature and amounts of such coverage;
- to administer the group benefits plan, including conducting audits and investigations;
- to provide benefits and assess any claim(s) made by me, my Dependants, or my beneficiary(ies); and
- to comply with applicable law

Access/Disclosure:

I understand that:

- the Personal Information will be kept on file by Empire Life;
- authorized Empire Life employees, representatives, its reinsurers and third party service providers will have access to this file, for the purposes listed above;
- Personal Information may be exchanged with the persons and organizations listed above if required for the purposes listed above. However, specific details relating to medical conditions will not be disclosed to my employer;
- in all cases, Empire Life restricts its collection, use, disclosure and retention of Personal Information to what is reasonably required for the purposes listed above;
- Empire Life may use third party service providers located inside or outside Canada to process and store the Personal Information; and
- I have the right to request access to the Personal Information in the file, as permitted or required by law, and, where appropriate, to have any accurate information corrected. I can access Empire Life's most recent Privacy Policy at www.empire.ca.

Other:

I understand that:

- the statements in this application form part of the application in consideration for the insurance applied for; and
- I also understand and agree that any material misrepresentation or non-disclosure of information on this declaration may render my coverage voidable.

I certify that the information given in this and other supporting documents is true, full and complete.

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 authorization will be as valid as the original.

Employee signature X	Date signed (dd/mmm/yy)