

GROUP ENROLMENT FORM

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

1. INFORMATION TO BE COMPLETED BY THE PLAN ADMINISTRATOR							
Name of Employer/Division			Group number	Division	Certificate/payroll number		
Departmental code (max 5 characters)		Occupation				Class	
Date of hire (dd/mmm/yy)		Effective date of coverage (dd/mmm/yy)		Number of hours/week			
Salary \$		Salary amount is: <input type="radio"/> Hourly <input type="radio"/> Weekly <input type="radio"/> Bi-weekly <input type="radio"/> Annual		<input type="radio"/> Commission \$		<input type="radio"/> Bonus \$	
Signature of Employer X				Date signed (dd/mmm/yy)			

2. INFORMATION TO BE COMPLETED BY THE EMPLOYEE							
Empire Life may use your email address and/or phone number to contact you for administrative purposes.							
Employee first name		Last name		Date of birth (dd/mmm/yy)		Sex <input type="radio"/> M <input type="radio"/> F <input type="radio"/> X	
Address (number, street, apt.)			City		Province	Postal code	
Email address			Phone number		Language <input type="radio"/> E <input type="radio"/> F	Do you have a spouse/partner? <input type="radio"/> married <input type="radio"/> single <input type="radio"/> common-law	
Provincial health coverage is required for the employee and all dependants.							
Claim payments: <input type="radio"/> 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				Name and address _____ 001 PAY TO THE ORDER OF _____ \$ _____ _____ DOLLARS BANK INFORMATION 12345 004 123 45678 Transit # Bank # Account #			
Transit number		Bank number		Account number			
Spouse/Child Information – Please list spouse and all children. If more space is required, attach a separate sheet. Specify how many dependants are listed: <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> more <input type="radio"/> none							
First name		Last name		Relationship (spouse, child)	Date of birth (dd/mmm/yy)	Sex (M/F/X)	Disabled child age 22 or older <input type="radio"/> yes <input type="radio"/> no
							Full-time student age 22 or older* <input type="radio"/> yes <input type="radio"/> no
							<input type="radio"/> yes <input type="radio"/> no
							<input type="radio"/> yes <input type="radio"/> no
*Complete the information below for a full-time student age 22 or older, attending a post secondary institution:							
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		Departure date (dd/mmm/yy)	

Note: The student must be attending an accredited post secondary institution, on a full-time basis. If more than one student, attach a separate sheet.



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").

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 Information.

Collection - I authorize Empire Life to collect Personal Information from any person or organization that has information relevant to this application and/or the group benefits plan, including but not limited to: my employer; health professionals and practitioners; plan administrators; advisors; reinsurers; government agencies; other insurance companies; and third party service providers.

Use - I authorize Empire Life to keep the Personal Information on file and use it for the purposes of administering my insurance.

Access/Disclosure

I understand that any information provided to or collected by Empire Life in accordance with this authorization will be kept on file with Empire Life. Access to my information will be limited to:

- Empire Life employees, representatives, reinsurers, and third-party providers (located inside or outside Canada) in the performance of their jobs;
- Persons to whom I have granted access; and
- Persons authorized by law.

I have the right to request access to the Personal Information in my file, and, where appropriate, to have inaccurate information corrected.

More specific details regarding how and with Empire Life collects, uses, maintains and discloses my Personal Information can be found in Empire Life's Privacy Policy and Group Privacy Information Page, available at:

<https://www.empire.ca/your-personal-information-and-your-privacy> and <https://www.empire.ca/group-privacy-information>

I understand and agree that:

- The statements in this form is considered part of the application in consideration for the insurance applied for; and
- Any material misrepresentation or non-disclosure of information on this declaration may render my coverage voidable.

I certify that the information given in this document is full, true and complete.

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

A photocopy of electronic copy of this authorization will be valid as the original.

I would like to receive electronic messages about products and services from Empire Life that are appropriate to my changing coverage needs. I understand that I can unsubscribe at any time by clicking the link at the bottom of Empire Life emails.

Employee signature

X

Date signed (dd/mmm/yy)

Please return the completed form to:

Group Admin

259 King St. East,

Kingston, ON K7L 3A8

Fax: 1 888 841-9145

Email: group.administration@empire.ca