



ENROLMENT FORM

Certificate # _____

PLEASE PRINT AND COMPLETE EACH SECTION CLEARLY IN INK.
REMIT SIGNED ORIGINAL TO RWAM AND KEEP A COPY FOR YOUR RECORDS.

EMPLOYER DATA

Employer _____ Group# _____ Div.# _____ Class _____ New Reinstatement

Permanent Full-time Hire Date _____ (Reinstatements indicate date of re-hire) (yy/mm/dd) Description of Occupation _____

Earnings _____ (Excluding Bonus/Dividend/Overtime Income) Salary (annual) Bi-Weekly Weekly Hourly Monthly Hours worked (per week) _____

EMPLOYEE STATEMENT

You and your dependents must be insured under your Provincial Benefit Plan in order to participate in RWAM's group insurance plan.

Employee's Surname _____ First Name _____

Date of Birth _____ (yy/mm/dd) Sex Female Male Address _____

Marital Status Single Common-law* Separated Married Divorced Widowed

*If Common-law, indicate date co-habitation began _____ (yy/mm/dd)

SINGLE, Extended Health Care SINGLE, Dental FAMILY, Extended Health Care FAMILY, Dental WAIVE, Extended Health Care WAIVE, Dental

If you are eligible for family coverage your dependents must have coverage* through your spouse

Spouse's Employer _____ Spouse's Group Insurance Carrier _____

Please indicate if you have coverage* through your spouse
E.H.C. No Yes
Dental No Yes
If 'Yes' indicate Spouse's Group Insurance Carrier _____

Spouse's Employer _____ Spouse's Group Insurance Carrier _____

Claims must be submitted to the primary carrier first. Any portion of the claim not reimbursed by the primary carrier should be sent to the secondary carrier for consideration. Children's claims are reimbursed by the plan of the parent whose date of birth falls first in the calendar year.

* If comparable coverage ceases, you must notify RWAM within 31 days or you will be subject to medical evidence (at your expense) and a one year dental restriction.

ELIGIBLE DEPENDENTS

Name (state surname if different than employee's)	Date of Birth (yy/mm/dd)	Name (state surname if different than employee's)	Relationship to Employee	Date of Birth (yy/mm/dd)
Spouse _____	_____	Children* _____	_____	_____
Students aged 21 or over and under 25 (or as specified in your plan) are only eligible if they submit confirmation of full-time registration.				
*Children of common-law spouses must reside with the employee to be eligible.				

BENEFICIARY DESIGNATION

I revoke all prior beneficiary designations under this certificate. I hereby designate the following person(s) to receive all group life insurance benefits payable on my death. If more than 1 person is named, proceeds are to be shared equally, unless otherwise stated below. A separate Beneficiary Designation/Change form is required to name contingent beneficiaries.

Beneficiary (ies) *-> Name(s) (first, middle initial, last)	Relationship to Insured	% Shares (must = 100%)	Trustee * If a beneficiary is under age 18: Consider naming a Trustee as benefits cannot be paid to a minor. Benefits will be paid to the named Trustee (regardless of beneficiary age) unless you change the designation to remove the Trustee. Trustee Name (first, middle initial, last)	As Trustee for (beneficiary name)	Relationship to Beneficiary
_____	_____	_____%	_____	_____	_____
_____	_____	_____%	_____	_____	_____
_____	_____	_____%	_____	_____	_____

AUTHORIZATION

I understand the information I provide on this form will be used by RWAM Insurance Administrators Inc.(RWAM) and the insurer for the purposes of determining eligibility for group insurance coverage and benefits; and to administer benefits under this coverage. I hereby authorize my employer/plan administrator, the authorized group agent/broker, and the insurer to exchange any relevant and necessary information for such purposes. If I am applying for coverage for my eligible dependents, I confirm I am authorized to act on their behalf for such purposes. I declare that the statements made on this form are complete and true. I understand that if any statement is incomplete or false, any coverage granted may be voided. This authorization will remain valid for as long as I am claiming benefits or service, or until revoked by myself.

Employee's Signature X _____ Date _____ (yy/mm/dd)

OFFICE USE ONLY

Effective Date _____	Life Volume <input type="checkbox"/> GF	WI Volume <input type="checkbox"/> GF	LTD Volume <input type="checkbox"/> GF	Extended Health Care <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Nil	Dental <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Nil
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FOR ELECTRONIC DEPOSIT OF BENEFITS COMPLETE REVERSE



APPLICATION FOR ELECTRONIC DEPOSIT OF GROUP BENEFIT PAYMENTS

INFORMATION

Electronic deposit of funds allows RWAM Insurance Administrators Inc. to deposit your Group Benefits payments directly to your bank, trust company or credit union account.

We hope you find this service convenient as your claims payment will automatically appear in your account each time a claim is submitted and approved. A corresponding Explanation of Benefit (E.O.B.) letter will be mailed to you explaining the benefit payment, or if you prefer, this explanation of benefit can be e-mailed to you. Please indicate how you would like to receive your E.O.B. and include e-mail address, if desired.

With this service you avoid mailing delays, lost or stolen cheques.

To have your claims benefit payment deposited electronically, simply complete this form and return it to us along with a personalized cheque marked "VOID".

If your banking information changes, we require at least 3 weeks notice to avoid any delay in your payment.

Please return this form and your void cheque to:

RWAM Insurance Administrators Inc.
Group Administration Department
49 Industrial Drive
Elmira, ON N3B 3B1

Or fax the form and voided cheque to (519) 669-1923

AUTHORIZATION

RWAM Insurance Administrators Inc. – Company Privacy Statement

RWAM Insurance Administrators Inc. is committed to protecting the privacy, confidentiality, accuracy and security of personal information it collects, uses, retains or discloses in the necessary conduct of our business.

Authorization

I hereby authorize RWAM Insurance Administrators Inc. to deposit Group Benefits (Extended Health, Dental and/or Disability) payments directly to my account and to exchange my relevant financial information with my financial institution for such purposes. This authorization shall remain valid until revoked by me in writing. Any copy of this authorization shall be as valid as the original.

Employee Name _____ Employer Name _____
Group # _____ Certificate # _____ Financial Institution _____
Home Address _____ Branch Address _____

I would like my E.O.B. sent to my: E-mail address (indicate e-mail address) _____

Home address **Disclaimer:** The transfer of any personal information by e-mail is not 100% secure. Your consent to transfer information by e-mail is given with this knowledge and understanding, and RWAM Insurance Administrators Inc. does not accept any responsibility for any interceptions of e-mails by unauthorized parties.

Employee Signature X _____ Date (yy/mm/dd) _____

Please include a personal cheque marked "VOID".

BANKING VERIFICATION

If a void cheque is not included, please have the following completed by your financial institution.

Bank # _____ Branch # _____ Account # _____

Name(s) of Account Holder _____

Signature of Branch Officer X _____ Date (yy/mm/dd) _____

Title _____ Branch Phone #(including extension) _____