ENROLMENT FORM

- **PLEASE PRINT and complete each section clearly in ink.**
- **Remit a signed original to RWAM and keep a copy for your records.**
- **Employee must meet all eligibility requirements as noted in the Employee Benefits Booklet.**
- **You and your dependents must be insured under your Provincial Benefit Plan in order to participate in RWAM's group insurance plan.**

Certificate # _____

EMPLOYER DATA

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

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

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

EMPLOYEE STATEMENT

Employee's Surname _____ First Name _____

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

Marital Status: ☐ Single ☐ Common-law* ☐ Separated ☐ Married ☐ Divorced ☐ Widowed

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

Address _____

Email - necessary for online claims submissions _____

☐ SINGLE, Extended Health Care
☐ SINGLE, Dental ⇨ If you are eligible for family coverage your dependents must have coverage* through your spouse
Spouse's Employer _____
Spouse's Group Insurance Carrier _____

☐ FAMILY, Extended Health Care
☐ FAMILY, Dental ⇨ 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 _____
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.

☐ WAIVE, Extended Health Care
☐ WAIVE, Dental ⇨ To waive coverage you and your dependents must have coverage* through your spouse.
Spouse's Employer _____
Spouse's Group Insurance Carrier _____

* 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)	Relationship to Employee
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 student status.

* 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, including Critical Illness, 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 & 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 & 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. I authorize my employer to deduct from my pay and remit to RWAM any applicable group benefit contributions. 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 ☐ GF	STD Volume ☐ GF	LTD Volume ☐ GF	Extended Health Care ☐ Single ☐ Family ☐ Nil	Dental ☐ Single ☐ Family ☐ Nil

FOR DIRECT DEPOSIT OF BENEFITS COMPLETE REVERSE

RWAM INSURANCE ADMINISTRATORS INC. 49 Industrial Dr., Elmira, ON N3B 3B1 ph. 519-669-1632 1-877-888-7926 fx 519-669-1923

APPLICATION FOR DIRECT DEPOSIT OF GROUP BENEFIT PAYMENTS

Necessary for online claims submissions

BENEFITS OF DIRECT DEPOSIT

Direct Deposit of Group Benefit Payments (otherwise known as Electronic Funds Transfer or 'EFT') allows RWAM to deposit your approved benefit payments directly into your personal or joint bank account (your name must be on the account).

You will be e-mailed once your claim is processed, and a corresponding Explanation of Benefits ('EOB') statement will be made available to you, explaining the benefit payment and/or decision.

Advantages of this convenient service include: Quick, safe and confidential**,** eliminates risk of lost or delayed benefit cheques**, c**onvenient, no extra trips to the bank, and it's more environmentally friendly.

EMPLOYEE & BANKING INFORMATION

Employee Name _____ Group # _____ Certificate # _____

Send my Explanation of Benefits (EOB) to my personal e-mail address at _____

Attach Your Cheque Marked "VOID"

If you are do not have a chequing account, we recommend that you confirm the account information you are providing with your financial institution.

Return this form and your VOID cheque by mail, fax or email to:

RWAM Group Administration Department
49 Industrial Drive, Elmira, ON N3B 3B1
Fax: 519-669-1923
email: **csr-groupadmin@rwam.com**

If a void cheque is not included, complete the following:

Sample cheque number pattern

Name(s) of Account Holder (as it appears on the cheque) _____

Name & Address of Financial Institution _____

Financial Institution # ___ ___ ___ (3 digits)

Branch/Transit # ___ ___ ___ ___ ___ (5 digits)

Account # _____
(If your Acct. # starts with zero, be sure to include the zero. Do not include dashes, hyphens or any other punctuation.)

NOTES:

- If you don't have cheques and are unfamiliar with how to complete the above, contact your financial institution or your Plan Administrator to make sure you are providing RWAM with the correct information. Inaccurate or missing information can result in delays or errors.
- You must be the sole or ***joint*** (generally jointly with your spouse) account holder at a Canadian financial institution & have signing authority.
- Applications for deposit to a third party's account will be rejected.

AUTHORIZATION

I hereby authorize RWAM Insurance Administrators Inc. to deposit Group Benefits (Extended Health, Dental and/or Disability) payments directly to my personal/joint bank 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 Signature *x* _____ Date (yy/mm/dd) _____