Equitable Life of Canada®

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NEW PLAN MEMBER GROUP INSURANCE APPLICATION

IMPORTANT NOTE: Plan Administrators: Please keep the signed original of this application for all Plan Members who are applying for Group insurance benefits. In the event of a Life claim, the original will be required, and we may request originals for audit purposes in other situations. Incorrect or incomplete information may affect payment of claims. Please type or print all information.

1. PLAN SPONSOR INFORMATION To be completed by the Plan Administrator

Name of Policyholder			Policy Number
Division	Class	Billing Sort Code (if applicable)	Certificate Number
Plan Member's name (first, middle, last)			Number of hours worked per week
Occupation	Date Employed Full Time (mm/dd/yyyy)	Income: ☐Hour ☐Year ☐Week ☐Other: $_____ per ☐Month	

2. PLAN MEMBER INFORMATION

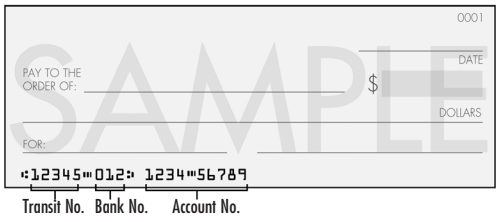
It is critical that you provide your email address so that Equitable Life can send you a plan member kit and notification when claims have been processed.

Date of Birth (mm/dd/yyyy)	☐Male ☐Female	Preferred Language: ☐English ☐French	
Address (number, street and apartment)	City or Town	Province	Postal code
Email Address			

3. DIRECT DEPOSIT

☐I authorize Equitable Life to deposit Group Claim payments directly into my bank account.

Bank Name	Bank Transit Number
Bank Number	Account Number



4. CONFIRMATION OF PROVINCIAL HEALTH COVERAGE (e.g. OHIP, RAMQ) Provincial health coverage is required.

I am covered under the provincial health plan: ☐Yes ☐No	If no, please indicate the date that your provincial health coverage will be in effect (mm/dd/yyyy)
My dependents are covered under the provincial health plan: ☐Yes ☐No	If no, please indicate the date that your dependents' provincial health coverage will be in effect (mm/dd/yyyy)

For residents of British Columbia, Manitoba and Saskatchewan only: In order to ensure that you and your dependents (if applying for family coverage) have access to the maximum prescription drug coverage available, you and your dependents must be registered for your provincial drug coverage program. If you and your dependents (if applying for family coverage) are registered for your provincial drug coverage program, please attach a copy of the provincial ministry letters or documents that provide proof of registration. Please note that if you are not registered for your provincial drug coverage program, you may receive a reminder about the requirement to register. If you do not register (or provide proof of registration) after receiving a reminder, your drug claims may be declined.

For more information on your provincial drug coverage program, please visit:
https://pharmacare.moh.hnet.bc.ca http://www.gov.mb.ca/health/pharmacare/ http://www.health.gov.sk.ca/special-support/

5. YOUR SELECTIONS FOR HEALTH AND DENTAL BENEFITS

For the purposes of this Policy, "Spouse" means: a) your legally married husband or wife, or b) your partner (a person of the same or opposite sex who resides with you in a conjugal relationship and who you publicly represent as your partner). "Child" means: Your natural child, stepchild, adopted child, child you have been granted final guardianship or custody of by an order of the Court, or child of your spouse. Your child must normally reside with you or your spouse.

Health	Dental		Health	Dental	
☐	☐	Myself ONLY	☐	☐	Myself and 2 or more dependents (spouse and child(ren))
☐	☐	Myself and 1 dependent (spouse or child)	☐	☐	None, because we are covered under another plan

I understand that I can join the Health/Dental plan with Equitable Life if I apply within 31 days of the termination of my spouse's/partner's coverage with his/her Employer. If I apply more than 31 days after the termination of my spouse's/partner's coverage, evidence of insurability will be required, and Dental coverage will be restricted. If I and/or my dependents have no current Group coverage, I understand I/we can apply in the future only with satisfactory evidence of insurability and coverage may be restricted or denied.

6. COORDINATION OF BENEFITS

Does your spouse/children have Health coverage under their own insurance plan? ☐ Yes ☐ No
Name of other carrier:

Does your spouse/ children have Dental coverage under his/her own insurance plan? ☐ Yes ☐ No
Name of other carrier:

You can submit claims under one plan and submit any remaining unpaid amounts to the other plan.

NOTE: Canadian Life and Health Insurance Association Regulations stipulate:

- A spouse/partner must submit claims to his/her own plan first.
- Claims for insured children must first be submitted to the plan insuring the spouse/partner whose month of birth is the earliest in the calendar year. If both spouses/partners were born in the same month, the earlier day would apply. Provide the name of your spouse's/partner's insurance carrier where indicated.

7. YOUR DEPENDENTS (Please include all eligible dependents for the Dependent Life benefit)

Full Name of Spouse or Partner (Common Law) (first, middle, last)	Date of Birth (mm/dd/yyyy)	Gender: ☐ Male ☐ Female
If Common-law, when did you begin living together as partners? (mm/dd/yyyy)		

Children: Children age 21 or older (or the maximum age for dependents as defined in the Group Policy) must be registered as a full-time student or qualify as a disabled dependent.

Name of Dependent (first, middle, last)	Date of Birth (mm/dd/yyyy)	☐ Male ☐ Female	☐ Full-time Student or ☐ Disabled
Name of Dependent (first, middle, last)	Date of Birth (mm/dd/yyyy)	☐ Male ☐ Female	☐ Full-time Student or ☐ Disabled
Name of Dependent (first, middle, last)	Date of Birth (mm/dd/yyyy)	☐ Male ☐ Female	☐ Full-time Student or ☐ Disabled
Name of Dependent (first, middle, last)	Date of Birth (mm/dd/yyyy)	☐ Male ☐ Female	☐ Full-time Student or ☐ Disabled

By providing the names of your dependents, your coverage will include them where applicable. If you have more dependent children, provide additional information on a separate sheet. Disabled Dependents age 21 and older may be eligible for coverage if certain conditions, as established by Equitable Life, are met. Form 441 - Application for Coverage of Dependent Child Over Age 21, along with an Attending Physician's letter must be submitted to Equitable Life for consideration.

8. BENEFICIARY INFORMATION

NOTE: a) If no beneficiary is appointed, the proceeds shall be paid as required by provincial law. b) If more than one beneficiary is appointed, proceeds will be payable in equal shares, unless otherwise indicated. c) You can change the appointed beneficiary at any time. d) If there are additional Primary and/or Contingent Beneficiaries, please sign, date and attach a note to this form with the beneficiary information. e) If all Beneficiary(ies) is/are deceased, the proceeds will be paid as required by provincial law. f) Please initial any corrections.

Full Name of Primary Beneficiary (first, middle, last)	Relationship to Plan Member	Gender: ☐ Male ☐ Female	% Share:
Full Name of Primary Beneficiary (first, middle, last)	Relationship to Plan Member	Gender: ☐ Male ☐ Female	% Share:
Full Name of Primary Beneficiary (first, middle, last)	Relationship to Plan Member	Gender: ☐ Male ☐ Female	% Share:

If the above Primary Beneficiary(ies) pre-deceases me, proceeds of the policy shall be payable to the following Contingent Beneficiary(ies):

Full Name of Contingent Beneficiary (first, middle, last)	Relationship to Plan Member	Gender: ☐ Male ☐ Female	% Share:
Full Name of Contingent Beneficiary (first, middle, last)	Relationship to Plan Member	Gender: ☐ Male ☐ Female	% Share:
Full Name of Contingent Beneficiary (first, middle, last)	Relationship to Plan Member	Gender: ☐ Male ☐ Female	% Share:

If the Beneficiary(ies) is/are under the age of majority at the time of my death, proceeds of the policy shall be payable to the following except in Quebec:

Name of Trustee for Beneficiary(ies): _____ Relationship of Trustee to Plan Member _____

For Quebec residents only: Designating your spouse as beneficiary is irrevocable unless you make the designation revocable. An irrevocable beneficiary designation cannot be changed without the written consent of the irrevocable beneficiary. A revocable beneficiary designation can be changed at any time without the consent of the revocable beneficiary.

I elect to make my spouse (married or civil union) designation: ❑ Revocable

9. AUTHORIZATION

The personal information collected by Equitable Life will be used by Equitable Life for the purposes of underwriting, servicing, managing and administering the group benefits plan, and claims processing and adjudication.

I authorize that for the above purposes the personal information is accessible to, and may be exchanged with, authorized employees of and relevant third parties retained by Equitable Life, its sales distribution network, the group benefits plan administrator, any industry drug pooling entity, participating reinsurers, other insurance companies, investigative organizations, health care providers and facilities, including, but not limited to pharmacies, physicians and dentists, and any other person or party I authorize.

If applying for my spouse and/or dependents, I confirm that I am authorized to act on their behalf and therefore this consent and authorization also applies to the collection, use and communication of their personal information for the same purposes. I understand that all claims made under the Group Insurance Policy are submitted through me as the plan member. I therefore authorize Equitable Life to exchange information about these claims with me or any person acting on my behalf, including a spouse or dependent, as deemed necessary for the purposes of confirming eligibility and assessing and managing the claim.

I certify that all of the information given on this form is true, correct and complete.
I designate the beneficiary(ies) stated above.

Plan Member Signature _____ Date (mm/dd/yyyy) _____