DCM benefits.com

Group Health & Dental

Toll Free: 1-866-405-9291 ~ Ph: 902-798-8897 ~ Fax: 902-792-2411
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P.O. Box 345, 42 Albert St. Windsor, NS B0N 2T0

EMPLOYEE APPLICATION / CHANGE FORM - MULTI COVERAGE PLAN

☐ New Enrollment
☐ Change Type of Change: _____

Employer / Plan Selection (to be completed by the plan administrator)

Company Name: _____

Date of Employment: _____ (mm/dd/yyyy) Start Date: _____ (mm/dd/yyyy)

Occupation: _____ Annual Earnings: _____

Current Duties: _____

Employee Direct Deposit Information: ***Attach copy of VOID cheque for direct deposit banking for claim reimbursement***

Employee / Participant Details (to be completed by the employee)

Last Name: _____ First Name: _____ M☐/ F☐

Address: _____

City/Town: _____ Postal Code: _____ Phone Home: _____

Email: _____ Date of Birth(mm/dd/yyyy): _____

SIN: _____ Marital Status: _____ Coverage Status: Single☐ or Family☐

Country of birth: _____

Dependent Details (to be completed by the employee)

(mm/dd/yyyy)

Spouse: Last Name: _____ First: _____ M☐/ F☐ DOB: _____

Child 1: Last Name: _____ First: _____ M☐/ F☐ DOB: _____

Child 2: Last Name: _____ First: _____ M☐/ F☐ DOB: _____

Child 3: Last Name: _____ First: _____ M☐/ F☐ DOB: _____

Child 4: Last Name: _____ First: _____ M☐/ F☐ DOB: _____

Please indicate below if any of your dependents are full time students over age 21

Name of over age student	College/University Attended	Enrolled From	Enrolled To

Please indicate the name of any disabled dependents

_____

If the dependant is not a resident of the same province as you (the employee), please note their province: _____

Co-ordinator of Benefits / Refusal of Coverage (to be completed by the employee)

If you and/or your dependents are presently insured for Health Care and/or Dental benefits under your spouse's group policy you may co-ordinate benefits or refuse coverage under this contract by completing the appropriate areas.

My spouse has coverage through _____ (insurance company), under policy No. _____

☐ I wish to co-ordinate coverage with my spouse's plan
☐ I refuse insurance on myself and dependents under: ☐ Health ☐ Dental
☐ I refuse insurance on my dependents under: ☐ Health ☐ Dental

Plan Refusal

I, _____, am covered under another plan and have been offered the opportunity to participate in my employer's employee benefit program. I understand the benefits offered and I do not wish to enroll in the following benefits (please specify below);

☐ Complete Group Benefit package (or specify the following benefits)
☐ Health and Dental Coverage
☐ Life, AD&D and Long Term Disability Coverage

I understand that by refusing the benefits specified above, my heirs /beneficiaries and I have no claim, now or in the future, for benefits under the program. I hold my employer, its representatives and the insuring company(ies) harmless from all future claims. I also understand that it is my responsibility to notify my employer of any status changes that may affect my benefits. If I wish to participate in the employee benefit program at a later date or do not notify my employer of a status change within 31 days, participation will be subject to the insurer's approval. I may be required to provide evidence of my good health and/or my dependents' good health.

_____	_____	_____
Sign here *ONLY* for plan refusal	Witness	Date: (mm/dd/yyyy)

Terms and Conditions

Please read carefully before signing

Declaration

I hereby apply for insurance to Western Life Assurance Company (Western Life) declare that the statements contained in this application, including but not limited to the Underwriting Questionnaire originally attached hereto, are true and complete and, together with any other forms signed by me in connection with this application, form the basis for any policy or certificate issued hereunder. I have read and understand the exclusions and limitations that apply.

Personal Information Consent - Western Life

The information collected on this application for insurance is required for the purposes of considering and, if approved, processing this application for insurance. It may also be used to administer the insurance policy, investigate any claims that may be made under this policy, and for the provision of products and services. This information, and information in existing files, may be used by and exchanged among Western Life Insurance Company, their agents, affiliates, partners, subsidiaries, reinsurers, rating agencies and authorized administrators for these purposes, regardless of whether a policy is issued or coverage ceases to be in force. Subject to legal and contractual requirements, the applicant may refuse to consent to the collection, use, or disclosure of their personal information for specific purposes by contacting privacy@westernlife.com or by calling *1-888-647-LIFE (5433)* and asking to speak to the Privacy Officer. By signing this document I acknowledge that I have read the above statement and agree to the terms and conditions contained within.

Personal Information Consent - DCM benefits

DCM benefits is committed to protecting your privacy, in compliance with all laws, including the Personal Information Protection and Electronic Documents Act ("PIPEDA").

Subject to legal and contractual requirements, the applicant may refuse to consent to the collection, use, or disclosure of their personal information for specific purposes by contacting service@dcmbenefits.com or by calling *1-866-405-9291* and asking to speak to the privacy officer. By signing this document I acknowledge that I have read the above statement and agree to the terms and conditions contained within.

For a copy of our privacy policy please visit www.dcmbenefits.com

DCM benefits.com

Authorization and Declaration

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or other organization, institution or person, that has any records or knowledge of me or my health, to give to Western Life Assurance Company, or its reinsurers, any such information. I understand that concealment, misinterpretation, or a false declaration on this application could cause my insurance to be void. A photographic copy of this authorization shall be as valid as the original. The parties have requested this application be drafted in English. Les parties ont exige que cette demande soit redigee en anglais.

Member and Spouse (*if applicable*) Signature(s)

Member's Signature: _____ Date (mm/dd/yyyy): _____

Spouse's Signature: _____ Date (mm/dd/yyyy): _____
(if applying for spousal coverage)

Do you wish to receive electronic communications and updates from DCM benefits in the future? Yes ☐ No ☐

If *No*, please call 1-866-405-9291

Employer / Plan Selection (to be completed by plan administrator)

Allotment Assignment (for health spending plan fill out this section)

Company Name: _____

_____
Name of Administrator

Phone Number Administrator: _____ Email: _____

Employee's Name (if not same as administrator): _____

Annual Allotment: $_____ Start Date (mm/dd/yyyy): _____

Other Instructions: _____

_____

Signature of Administrator / Owner: _____ Date (mm/dd/yyyy): _____

Defined Plan (for defined benefit plan fill out this section)

Company Name: _____

Name of Administrator: _____ Start Date (mm/dd/yyyy): _____

Other Instructions: _____

_____

Signature of Administrator / Owner: _____ Date (mm/dd/yyyy): _____

facsimile signatures are acceptable