



Please print clearly in INK. Once you have completed this form and attached any additional documentation required, you must mail the original form to D&R Insurance Administration Inc., address found at the bottom of this form. If you have any questions, please call D&R Insurance at 905.819.9699 or toll free 1.800.521.0023.

Name of Policyholder/Employer			Certificate No.
Policy #	Division No.	Class (if applicable)	Date Employed (DD/MM/YYYY)
Salary \$	Per <input type="checkbox"/> Hour, Number of Hours worked per week <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year		Occupation

SECTION 1: EMPLOYEE/MEMBER

First Name	Last Name	Date of Birth (DD/MM/YYYY)	
Full Mailing Address		<input type="checkbox"/> Smoker <input type="checkbox"/> Non Smoker	Marital Status Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
City	Province	Postal Code	Home Phone Number (Including area code) ()

SECTION 2: COVERAGE OPTIONS I wish to participate in Health Care Single Family
 Dental Care Single Family

Note: If you waive health and dental coverage, you MUST complete Section 5. See reverse.

First Name	Initial	Last Name	Relationship	Gender	Date of Birth (DD/MM/YYYY)	* If Dependent is a student under age 25 check below

* If any of the above dependents are full time students, under age 25, indicate the name of University or College being attended - include dates of attendance.

Name of Child	Name of School Attending	Date of Attendance (DD/MM/YYYY)
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SECTION 3: CO-ORDINATION OF BENEFITS (Complete only if Family coverage has been selected)

Does Your Spouse have coverage available under any other plan? No Yes, please indicate type of coverage Medical Dental

Do your dependent children have coverage available under any other plan? No Yes, please indicate type of coverage Medical Dental

Is/are child(ren) physically or mentally handicapped and primarily dependent on you for support?

No Yes, Name: _____

If, for legal reasons, you are required to provide the primary coverage for your dependent children named above under the plan, please attach a copy of the supporting legal documentation.

SECTION 4: BENEFICIARY DESIGNATION

PRIMARY BENEFICIARY(IES) In equal shares unless otherwise provided below:

First Name	Last Name	Relationship to insured	Date of Birth (DD/MM/YYYY)	% Allocated
First Name	Last Name	Relationship to insured	Date of Birth (DD/MM/YYYY)	% Allocated
First Name	Last Name	Relationship to insured	Date of Birth (DD/MM/YYYY)	% Allocated

If no % Allocated is indicated, benefit will be divided equally.

CONTINGENT BENEFICIARY(IES) In the event that the Primary Beneficiary(ies) dies. In equal shares unless otherwise provided below:

First Name	Last Name	Relationship to insured	Date of Birth (DD/MM/YYYY)	% Allocated
First Name	Last Name	Relationship to insured	Date of Birth (DD/MM/YYYY)	% Allocated
First Name	Last Name	Relationship to insured	Date of Birth (DD/MM/YYYY)	% Allocated

If no % Allocated is indicated, benefit will be divided equally.

**MINOR CLAUSE - Complete if any Beneficiary is under 18 years old:
TRUSTEE FOR CHILDREN**

First Name	Last Name	Relationship to insured
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Is hereby appointed Trustee to receive any payment due on or after the life insured's death to any BENEFICIARY DESIGNATED in this form who is a minor on the date of such payment falls due. I reserve the right to change this designation of beneficiary. The company assumes no responsibility for the validity or effect of this designation.

SECTION 5: WAIVER OF GROUP HEALTH AND/OR DENTAL BENEFITS

I understand the plan of group benefits offered to me, but I decline to participate in:

- Health care **for** Myself and my dependents My dependents only Myself, I decline to participate.
 Dental care **for** Myself and my dependents My dependents only Myself, I decline to participate.

If you have indicated above that you decline coverage for yourself and/or your dependents because coverage is offered through another policy, please provide policy information below:

Name of Employer	Policy #	Name of Insurance Carrier	Effective Date of Coverage (DD/MM/YYYY)
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If you lose spousal coverage you must apply for coverage within 31 days of loss of such coverage. If you do not apply within 31 days you may be required to provide proof of your insurability acceptable to insurance company to be covered. If you are approved, dental benefits, if applicable, may be limited. Please contact D&R Insurance Administrators Inc. Note: If you are declining coverage for yourself and wish to apply in the future, proof of insurability may be required.

I apply for the following coverage under the policy or policies indicated above. If any contributions are required to be made by me, I authorize deductions to be taken from my pay.

Protecting your personal information. Your privacy is recognized and respected at D&R Insurance Administrators Inc. When applying for coverage, a confidential file will be established and kept in our office or the offices of an organization authorized by D&R Insurance Administrators Inc. We limit access to the information in your file to D&R Insurance Administrators Inc. or persons authorized by D&R Insurance Administrators Inc. who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use the information to determine your eligibility for coverage and to administer the Group Benefit Plan.

DATE (DD/MM/YYYY)	AUTHORIZED SIGNATURE	DATE (DD/MM/YYYY)	Signature of Plan Administrator (if applicable)
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