CAAT – Academic staff – Partial-load
Contract no. 50832
Group insurance benefits – Positive Enrolment form

(Please read carefully before completing this form)

The purpose of this form is to record all relevant data and, where applicable, elections made by employees. If you have any questions or need assistance in completing this form, please contact your College's Benefits Administrator.

The date coverage begins will be determined by the College in accordance with the waiting period provisions outlined in the Group Insurance Benefits contract with Sun Life Assurance Company of Canada (Sun Life), the details of which are described in your Group Insurance Benefits booklet.

Section 1 – General information

This information is required by the College to set up your records and is communicated to Sun Life in order for you to be reimbursed for claims for eligible expenses in accordance with the Academic Staff Group Insurance Contract. This information is protected under the Freedom of Information and Privacy Act, and will be used for the purpose of administering the Group Insurance Benefits Program.

Section 2 and 3 – Optional benefits

Please indicate:

1. Your election of either single or family coverage under both the Extended Health Care and Dental Care plans or complete the declination box.
2. Your election or declination of both the Vision Care and Hearing Care coverage.

Section 4 – *Coverage under more than one Group Insurance Plan – Co-ordination of Benefits (CoB)*

If you have Extended Health Care, Vision Care, Hearing Care, or Dental Care coverage under your spouse's/partner's or any other Group Insurance Plan, the Co-ordination of Benefit provision allows claims to be made under both plans. You are required to provide details surrounding coverage under any other plan on this form. The rules for benefit co-ordination are as follows:

1. You must submit claims for your eligible expenses to the College plan first, and in the event there is still a portion of the claim unpaid and it is an eligible expense it can be submitted to your spouse's/partner's plan. Your spouse/partner must submit his/her claims to their plan first, and in the event there is still a portion of the claim unpaid if it is an eligible expense it may be submitted to the Colleges' plan.
2. Covered children must be claimed first from the plan covering the parent with the earlier date of birth in the year. If both parents were born in the same month, use the earlier date in the month.

Section 5 – Dependent information

This information is required in order for your College and Sun Life to ensure the effective administration of the Group Insurance Benefits for you and your dependents. If your dependent is over age 21, please note the special documentation required.

Section 6 – Optional Life benefits

PLEASE NOTE: If you decline coverage under any of these benefits, future enrolment may be subject to proof of good health. Under Supplementary Life, Dependent Life and Employee Pay-All Life Insurance, future changes may be made without proof of good health within 31 days of a personal status change such as marriage, divorce, acquiring a dependent child, etc.

1. **Supplementary Life** – elect the amount of coverage or complete the declination of coverage box.
2. **Employee Pay-All Life** – if you have elected the maximum coverage under item 1. Supplementary Life above, and wish additional coverage, elect the amount of coverage or complete the declination of coverage box.
3. **Dependent Life** – elect the amount of coverage or complete the declination of coverage box.

Important note: To add or update a beneficiary for your Basic Life, Accidental Death and Dismemberment, Supplementary Life or Employee Pay-All Life benefits, please complete the beneficiary nomination process available through *mysunlife.ca* or complete a beneficiary nomination form and return it to your College Benefit Administrator. If no beneficiary is named, or your beneficiary predeceases you, death benefits will be paid to your estate.

If you are changing your beneficiary nomination and your current nomination is irrevocable, your current beneficiary must agree to revoke their rights by completing a Consent by Beneficiary form.

Section 7 – Banking details

Make sure to provide your banking information by attaching a void cheque, direct deposit form or bank verification statement. This information is treated as confidential information and safeguarded in accordance with applicable privacy legislation including Personal Information and Electronic Documents Act (PIPEDA) and will be used for the the purpose of depositing your Extended Health Care and/or Dental Care benefit payment directly into your bank account.

Section 8 – Authorisation and signature

This completes your application for benefits, agreement to pay any required premiums, and certification that the information provided is correct.

CAAT – Academic staff – Partial-load
Positive Enrolment form for Group insurance benefits

Sun Life

Do you have a current Partial-load contract at another College? ☐ Yes ☐ No

Have you had a Partial-load contract at another College that ended in the last 6 months? ☐ Yes ☐ No

College name: Certificate number:

Optional benefits declined during your initial Partial-load contract will not be available at any subsequent College where you may be employed. There must be a break of more than 6 months between Partial-load contracts before you are considered a new Partial-load employee.

☐ Enrolment form ☐ Change form Date of transfer (yyyy-mm-dd):

Transferred from: Contract number: Sub acct. number: Certificate number:

☐ Survivor of

Name: Date of birth (yyyy-mm-dd):

Certificate number:

Clear

1 General information

Entire form to be completed by **EMPLOYEE**.

Please **PRINT CLEARLY**.

Last name	First name	Middle name	Date of birth (yyyy-mm-dd)	☐ Male ☐ Female

To be completed by the College.

Contract number	Sub account number	Employee certificate number (for group insurance purposes only)
50832		

Date of hire (yyyy-mm-dd)	Earnings
	$ ☐ Hr. ☐ Mo. ☐ Yr.

2 Basic benefits

I understand that I may elect the following benefit coverage as described in my benefits booklet.

☐ **I ELECT** Extended Health Care (Check applicable box below)
(Includes semi-private hospital)

Coverage effective on (yyyy-mm-dd)

Single coverage
☐ Employee only

Family coverage
☐ Family

☐ **I DECLINE** to participate in this benefit. I understand that if I request this benefit at a later date, I may be required to submit evidence of Insurability at my own expense and may be declined for coverage at that time.

3 Optional benefits

Vision and Hearing Care requires Extended Health Care election to participate.

☐ **I ELECT** Vision Care
(Dependent coverage to be the same as I have selected under the EHC benefit.)

Coverage effective on (yyyy-mm-dd)

☐ **I DECLINE** to participate in this benefit. I understand that I will not be able to enrol in this benefit at any future dates.

☐ **I ELECT** Hearing Care
(Dependent coverage to be the same as I have selected under the EHC benefit.)

Coverage effective on (yyyy-mm-dd)

☐ **I DECLINE** to participate in this benefit. I understand that I will not be able to enrol in this benefit at any future dates.

3 Optional benefits (continued)

☐ **I ELECT** Dental Care (Check applicable box below)

Coverage effective on (yyyy-mm-dd)

Single coverage	Family coverage
☐ Employee only	☐ Family

☐ **I DECLINE** to participate in this benefit. I understand that I will not be able to enrol in this benefit at any future dates.

4 Coverage under more than one Group Insurance Plan – Coordination of benefits

If you or your Dependents are covered under more than one Group Extended Health and/or Dental Care benefits plan, the "Co-ordination of Benefits" provision allows claims to be made under more than one plan with total reimbursement received under all plans limited to a maximum of 100% of the actual expenses incurred. Please refer to your benefits booklet for details. Please "X" appropriate box.

☐ My spouse/partner has coverage under his/her employer's Plan

Name of spouse/partner's employer		
Name of insurance carrier	Contract number	Effective date of coverage (yyyy-mm-dd)

☐ My spouse/partner is covered as an employee under the Colleges' Plan

Name of college	Contract number

☐ I do not have a spouse/partner ☐ My spouse/partner does not have coverage

☐ I do not have coverage under another Group Insurance Plan

☐ I have coverage under another Group Insurance Plan

Name of insurance carrier	Contract number

If you or your spouse/partner is covered for Group Extended Health and/or Dental Care benefits by another Group Insurance Plan, please indicate the coverage:

Extended Health Care: ☐ None ☐ Single ☐ Family

Dental: ☐ None ☐ Single ☐ Family

5 Dependent information

You are **required** to provide the names and birth dates of your spouse/partner and dependent children. *If the last name of your spouse or any of your children is* **different from your last name**, *make sure you have shown it on this form to eliminate any claim payment problems*. If your dependent child is over age 21 and in full time attendance at an educational institution (check the box below), provide the name and address of the educational institution and current semester period along with proof of registration with this application. You will be required to provide this information at the beginning of each school year to the Benefits Administrator. If your dependent child is over age 21 and is disabled (check the box below), provide a doctor's letter clearly stating the nature of the disability, diagnosis, limitations and any course of treatment. Updates on this information may be required from time to time. Expenses incurred relating to the required documentation for continuation of coverage will be the responsibility of the employee.

Spouse/Partner last name	First name	☐ Male ☐ Female	Date of birth (yyyy-mm-dd)

Child's name		Relationship to you		Date of birth (yyyy-mm-dd)	Child over 21	
		Son	Daughter		Full-time student	Disabled
Last	First	☐	☐		☐	☐
Last	First	☐	☐		☐	☐
Last	First	☐	☐		☐	☐
Last	First	☐	☐		☐	☐
Last	First	☐	☐		☐	☐

6 Optional Life benefits

I understand that I may elect the following benefit coverage as described in my benefits booklet.

Coverage terminates for Supplemental Life Insurance, Employee Pay All Life Insurance and Dependent Life Insurance at the end of the month you turn 65, but no later than August 31st following your 65th birthday if you are actively at work.

Basic Life Insurance and Accidental Death & Dismemberment

☐ **I ELECT** Basic Life Insurance and AD&D coverage:
- ☐ $25,000

Coverage effective on (yyyy-mm-dd)

☐ **I DECLINE** to participate in this benefit. I understand that if I request this benefit at a later date, I may be required to submit proof of good health at my own expense and may be declined for coverage at that time.

Supplementary Life insurance

This coverage is available only if you have elected Basic Life Insurance coverage.

☐ **I ELECT** Supplementary Life Insurance coverage:
- ☐ $10,000 ☐ $20,000 ☐ $30,000
- ☐ $40,000 ☐ $50,000 ☐ $60,000

Coverage effective on (yyyy-mm-dd)

☐ **I DECLINE** to participate in this benefit. I understand that if I request this benefit at a later date, I may be required to submit proof of good health at my own expense and may be declined for coverage at that time.

Employee Pay-All Life insurance

This coverage is available only if you have elected the maximum coverage available under the Supplementary Life insurance.

☐ **I ELECT** the following Employee Pay-All Life insurance coverage in units of $10,000 each:
- ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8
- ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16
- ☐ 17 ☐ 18 ☐ 19 ☐ 20 ☐ 21 ☐ 22 ☐ 23 ☐ 24
- ☐ 25 ☐ 26 ☐ 27 ☐ 28 ☐ 29 ☐ 30

Coverage effective on (yyyy-mm-dd)

☐ **I DECLINE** to participate in this benefit. I understand that if I request this benefit at a later date, I may be required to submit proof of good health at my own expense and may be declined for coverage at that time.

Dependent Life Insurance

☐ **I ELECT** Dependent Life Insurance coverage:
Spouse – $5,000
Each dependent child – $2,000
I am the beneficiary of the Dependent Life benefit.

Coverage effective on (yyyy-mm-dd)

☐ **I DECLINE** to participate in this benefit. I understand that if I request this benefit at a later date, I may be required to submit proof of good health at my own expense and may be declined for coverage at that time.

7 Banking details

Your Extended Health Care and/or Dental Care benefit payment will be deposited directly into your bank account, attach a void cheque, direct deposit form or bank verification statement.

If you do not have a chequing account, you must provide a direct deposit form or bank verification statement from your bank branch. This form must be provided by your bank, trust company, caisse populaire or credit union in Canada, and be signed and stamped by a banking representative. If your bank provides an online direct deposit form, pre-populated with your banking information, this can also be submitted. These forms must contain your name, the Bank Number, your Branch Number and Account Number to facilitate your benefit payment being deposited directly into your account.

Bank name			
Address (street number and name)	City	Province	Postal code
Transit number / Bank code	Bank account number		
Employee's email address			

Please attach a void cheque, direct deposit form or bank verification statement

8 Authorization and signature

IMPORTANT: You must sign and date the form.

I am authorized to disclose information about my spouse and dependents in order to enrol them in the Plan.

By enrolling in this Plan, I authorize the following:

- Sun Life and it's reinsurers to collect, use and disclose relevant information about me to underwrite, administer, adjudicate and deposit claim payments,
- My plan sponsor to use the information collected in this form for benefits administration and to make any necessary payroll deductions which may be required,
- Sun Life and my plan sponsor to collect, use and disclose information about me, my spouse and dependents necessary for enrolment and for the purposes of continuing administration of the plan.

I understand that satisfactory proof of good health may be required for myself or my spouse to become covered or to increase Dependent Life, Supplementary Life or Employee Pay-All Life and for myself, my spouse or child(ren) to become covered or to increase Optional Critical Illness coverage.

I declare that the information above is accurate and true. Inaccurate information may invalidate my claim.

A photocopy or electronic version of this authorization is as valid as the original.

By signing my name OR by checking the check box besides "I agree", I hereby certify that I understand and agree to the above.

Employee's signature X	Date (yyyy-mm-dd)
☐ I agree	

In the event my Employee Certificate Number is my Social Insurance Number, I authorize the use of my Social Insurance Number for benefits' tax reporting, identification and record keeping, where applicable.

Employee's signature (in ink) X	Date (yyyy-mm-dd)

9 Respecting your privacy

Respecting your privacy is a priority for the Sun Life group of companies. We keep in confidence personal information about you and the products and services you have with us to provide you with investment, retirement and insurance products and services to help you meet your lifetime financial objectives. To meet these objectives, we collect, use and disclose your personal information for purposes that include: underwriting; administration; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; and we may tell you about other related products and services that we believe meet your changing needs. The only people who have access to your personal information are our employees, distribution partners such as advisors, and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize. Sometimes, unless we are otherwise prohibited, these people may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit *www.sunlife.ca/privacy*.

FOR OFFICE USE:

Benefits Administrator	
Benefits Administrator's signature X	Date (yyyy-mm-dd)