CAAT – Retirement Group insurance benefits program
Contract No. 22182
Positive Enrolment form

(Please read carefully before completing this form)

The purpose of this form is to record all relevant data and, where applicable, benefit elections made by employees/retirees. If you have any questions or need assistance in completing this form, please contact your College's Benefits Administrator. You are required to complete the form except the area designated as "For Benefits Administrator Use Only" and sign where applicable. The date coverage begins will be determined by the College in accordance with the provisions outlined in the Retiree Group Insurance Benefits Contract with Sun Life, the details of which are described in your Group Insurance Benefits Information Folder.

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 Retirement Group Insurance Benefits Contract. This information is protected under the Freedom of Information and Protection of Privacy Act, and will be used for the purpose of administering the Retiree Group Insurance Benefits Program.

Section 2 – Election of retirement benefit coverage

At retirement, you may elect coverage under Basic Retiree Life Insurance, Extended Health Care and/or Dental Benefits. If you are under age 65 at retirement, you may also elect coverage under Additional Life Insurance and Dependent Life Insurance. Benefit coverage is optional and any benefit that you decline at retirement is no longer available to you unless you are covered by your spouse/partner for Extended Health Care and/or Dental Benefits. If you are electing coverage under Extended Health Care or Dental Benefits, please indicate single or family coverage. Your enrolment form must be submitted to your Benefits Administrator within 31 days of retirement or loss of comparable coverage.

Important note: If you wish to designate or change your beneficiary nomination for your Basic Life or Optional 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 3 – Coverage under more than one Group Insurance Plan – Co-ordination of Benefits (CoB)

If you have Extended Health Care or Dental Benefit coverage under your spouse's/partner's or any other group insurance plan, the Co-ordination of Benefits 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:

- **Your claims** must be submitted to the College plan first. If there is any unpaid portion, the claim would then be submitted to your spouse's/partner's plan.
- **Your spouse's/partner's claims** must be submitted to their plan first. If there is any unpaid portion, the claim would then be submitted to the College's plan.
- **Your Children's claims** must be submitted to the plan of the parent who is born on the earliest month and day in the year. If there is any unpaid portion, the claim would then be submitted to the other parent's plan.

Section 4 – Dependent information

Your College and Sun Life require this information to ensure the effective administration of the Retirement Group Insurance Benefits for you and your dependents. If your dependent is over age 21, please note the special documentation that is required.

Section 5 – 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 6 – Authorization and signature

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

Documents that need to accompany this enrolment form

Dependent child over age 21

- Proof of student status where applicable (see enrolment form, Section 4 for details)
- Proof of disability status where applicable (see enrolment form, Section 4 for details)

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Sun Life

☐ Enrolment form ☐ Change form
☐ Survivor of

Name: _____ Date of birth (yyyy-mm-dd): _____ Certificate number: _____

Instructions

- Section 1 to be completed by the Benefits Administrator.
- Section 6 to be completed by the plan member and the Benefits Administrator.
- All remaining sections are to be completed by the plan member (except for Plan code(s) and Coverage effective date (yyyy-mm-dd) located in Section 2) and returned to your Benefits Administrator.

Please PRINT clearly. Complete the form in ink, sign and date the form and return to your Benefits Administrator for handling.

1 Information to be completed by benefits administrator

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

Address (street number and name)	Apartment or suite

City	Province	Postal code

Contract number	Sub account number	Member certificate number
22182		

Date of retirement (yyyy-mm-dd)	☐ Proof of receiving a lifetime monthly pension from the Colleges of Applied Arts and Technology Pension Plan

Marital status ☐ Single ☐ Married ☐ Common Law ☐ Civil Union ☐ Divorced ☐ Separated ☐ Widowed

2 Election of retirement benefit coverage

Important: To be eligible for Extended Health Benefits under this plan, you must have coverage through your Provincial Medicare plan (e.g. OHIP, RAMQ, MSP) or federal plan.

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

			For Benefits Administrator use only	
Basic Life Insurance – $10,000 (Academic – Terminates age 75; all other retirees – Lifetime)		☐ Yes ☐ No	Plan code(s)	Coverage effective date (yyyy-mm-dd)
Additional Life Insurance (Terminates at age 65) Units of $5,000; maximum no. of units: 98 ($490,000) Coverage amount: $5,000 X ____ (no. of units) = $ _____		☐ Yes ☐ No	Plan code(s)	Coverage effective date (yyyy-mm-dd)
Extended Health Care (EHC)	Single Coverage / Family Coverage		Plan code(s)	Coverage effective date (yyyy-mm-dd)
EHC Plan 1	☐ ☐	☐ Yes ☐ No		
EHC Plan 2	☐ ☐	☐ Yes ☐ No		
Dental Care	Single Coverage / Family Coverage		Plan code(s)	Coverage effective date (yyyy-mm-dd)
Dental Plan 1	☐ ☐	☐ Yes ☐ No		
Dental Plan 2	☐ ☐	☐ Yes ☐ No		

I understand that any Life Insurance not elected at date of retirement is no longer available to me at any future date. If I elect coverage under Extended Health Care Plan 1 and/or Dental Plan 1, I may move to Extended Health Care Plan 2 and/or Dental Plan 2 at any future February 1. If I elect coverage under Extended Health Care Plan 2 and/or Dental Plan 2, Extended Health Care Plan 1 and/or Dental Plan 1 are no longer available to me. If I do not elect coverage under any of Extended Health Care Plans or Dental Plans, they are no longer available to me at any future date.

3 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

4 Dependent information

You are required to provide the names and dates of birth of your spouse/partner and dependent children. Please note: If the last name of your spouse/partner 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.

Dependent child is over age 21 but under age 25 and a full-time student: If your dependent child is unmarried and age 21 but under age 25 and attending college or university as a full-time student, check the box beside their name and attach proof of registration to this application. Proof includes the name and address of the educational institution and current semester period. You will be required to provide your Benefits Administrator with this information at the beginning of each school year.

Dependent child is over-age 21 and disabled: If your dependent child is over-age 21 and is disabled, check the box beside their name. You, the College and dependent's physician must complete a "Disabled Child Coverage" form and submit it to Sun Life. You may obtain this form from your College Benefits Administrator. Updates to this information may be required from time to time. Expenses incurred relating to the required documentation for continuation of coverage will be your responsibility.

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	☐	☐		☐	☐

5 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			
Bank address (street number and name)	City	Province	Postal code
Transit number / Bank code		Bank account number	
Member's email address			

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

6 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 Pre-authorized deductions as 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 declare that the information above is accurate and true.

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

By signing your name OR by checking the box beside "I agree", you are hereby certifying that you understand and agree to the above.

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

In the event my 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.

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

7 Respecting your privacy

Our Purpose is to help our Clients achieve lifetime financial security and live healthier lives. We collect, use and disclose your personal information to: develop and deliver the right products and services; enhance your experience and manage our business operations; perform underwriting, administration and claims adjudication; protect against fraud, errors or misrepresentations; tell you about other products and services; and meet legal and security obligations. We collect it directly from you, when you use our products and services, and from other sources. We keep your information confidential and only as long as needed. People who may access it include our employees, distribution partners such as advisors, service providers, reinsurers, or anyone else you authorize. At times, unless we're prohibited, they may be outside your jurisdiction and your information may be subject to local laws. You can always ask for your information and to correct it if needed. In most cases, you have a right to withdraw your consent, but we may not be able to provide the requested product or service. Read our Global Privacy Statement and local policy at *www.sunlife.ca/privacy* or call us for a copy.

FOR OFFICE USE:

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