UCCM Anishnaabe Police Service
GROUP INSURANCE ENROLLMENT FORM
Group Plan #s ClaimSecure 37925
Sutton 056/031832A, 056/031833A, 056CI/031834A, 056CI/031835A

1. EMPLOYEE INFORMATION: ◯ New Application ◯ Change or Update

Last Name:	**First Name:**	**Initial:**
Home Address:		
Main Telephone Contact Number:	◯ **Cell** ◯ **Home** ◯ **Work**	
Personal E-mail Address:		
Payroll ID:	**Date of Birth: (mm/dd/yy)**	**Status** ☐ **or Non-Status** ☐
Gender ◯ Male ◯ Female ◯ Prefer not to answer		

2. ADDITIONAL BENEFIT PLAN – CLAIMSECURE & TELADOC

ClaimSecure: Psychological Benefit / Paramedical Services / Health Service Spending Account (HSSA) / Wellness Account. **Teladoc Services: Expert Medical; GenMed; EDIS; Mental Health Navigator; myStrength and Mental Health Care**	◯ **Family**	◯ **Single**

3. DEPENDANT INFORMATION:

Relationship To Employee	**Action**	***Last Name***	**First Name**	**Date of Birth (mm/dd/yy)**	**Gender**	**If dependent child is over 21 years of age**	
						Full-time Student	**Disabled**
□ Spouse or Common-law	□ Add □ Change □ Remove				□ Male □ Female		
□ Dependent Child	□ Add □ Change □ Remove				□ Male □ Female	□ Yes □ No	□ Yes □ No
□ Dependent Child	□ Add □ Change □ Remove				□ Male □ Female	□ Yes □ No	□ Yes □ No
□ Dependent Child	□ Add □ Change □ Remove				□ Male □ Female	□ Yes □ No	□ Yes □ No
□ Dependent Child	□ Add □ Change □ Remove				□ Male □ Female	□ Yes □ No	□ Yes □ No

4. BASIC INSURANCE COVERAGE

All Employees	**Basic Accidental Death & Dismemberment** Policy 056/031832A	Three (3) times Annual Earnings, rounded to the next higher $1,000 (if not already a multiple thereof) and maximum of $750,000	At age 65 reduces by 50%. Termination at age 70.
	Mandatory Critical Illness Policy 056CI/031834A.	$10,000	Termination at age 70.

5. OPTIONAL ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) PLAN Policy 056/031833A

◯ New Insurance	◯ Increase in Insurance	◯ Decrease in Insurance	◯ Cancel Insurance

Type of Coverage: ◯ Member Only Coverage ◯ Member & Family Coverage	Amount of Coverage: $50,000 to $250,000 in $10,000 increments NEW $ _____ CHANGE FROM $ _____ TO $_____

Rates are based on amount of coverage and type of plan, below are a few examples of coverage and cost (amounts are monthly and 8% Ontario premium tax will be added to amounts shown below, if applicable)

Member only plan	($0.056/$1,000)	$10,000 ; $0.56	$50,000 ; $2.80	$100,000 ; $5.60	$250,000 ; $14.00
Member/Family plan	($0.074/$1,000):	$10,000 ; $0.74	$50,000 ; $3.70	$100,000 ; $7.40	$250,000 ; $18.50

Please refer to the AD&D Plan Overview and Booklet which can be found on the UCCM internal SharePoint site "Benefit Plan- Additional Information" for information regarding policy coverages, terms, conditions, exclusions and premium details.

6. OPTIONAL CRITICAL ILLNESS INSURANCE PLAN Policy 056CI/031835A

◯ New Insurance ◯ Increase in Insurance	◯ Decrease in Insurance ◯ Cancel Insurance If you choose to re-apply after decreasing or canceling coverage, a new medical application may be required.	
◯ **MEMBER** ◯ Smoker ◯ Non-Smoker	Amount of Coverage: $5,000 to $100,000 in $5,000 increments $_____ Premium details in Plan Overview	**$5,000** added directly as Guaranteed Issue. **Over $5,000** medical approval required Optional CI Medical Application is available from the UCCM internal SharePoint site or Target Benefit Administrators.
Coverage is only available to spouse and children in amounts less than or equal to the amount of coverage on member.		
◯ **SPOUSE** ◯ Smoker ◯ Non-Smoker ◯ Male ◯ Female Name_____ Date of Birth_____ Status ◯ Yes ◯ No	Amount of Coverage: $5,000 to $100,000 in $5,000 increments $_____ Premium Details in Plan Overview	**$5,000** added directly as Guaranteed Issue. **Over $5,000** medical approval required Optional CI Medical Application is available from the UCCM internal SharePoint site or Target Benefit Administrators.
◯ **CHILD(REN)** Status ◯ Yes ◯ No	Amount of Coverage: $5,000 to $25,000 in $5,000 increments $_____ Premium Details in Plan Overview	**$5,000** added directly as Guaranteed Issue. **Over $5,000** medical approval required Optional CI Medical Application is available from the UCCM internal SharePoint site or Target Benefit Administrators.

Employee's signature_____ **Date**_____ This section applies to Critical Illness only.

Rates are based on age, gender and smoking status below are a few examples of coverage and cost (amounts are monthly and 8% Ontario premium tax will be added to amounts shown below, if applicable)

Female, age 30, non-smoker:	$5,000	$1.05	Female, age 35, smoker:	$5,000	$2.05
Male, age 30, smoker:	$5,000	$1.20	Male age 30, non-smoker:	$5,000	$0.90

Please refer to the Critical Illness Plan Overview and Booklet which can be found on the UCCM internal SharePoint site "Benefit Plan- Additional Information" for information regarding policy coverages, terms, conditions, exclusions and premium details.

7. APPOINTMENT OR CHANGE OF BENEFICIARY

Beneficiary designation:	Accidental Death & Dismemberment – Sutton Special Risk Optional Accidental Death & Dismemberment – Sutton Special Risk

Primary Beneficiary(s): if designating percentages, they must equal 100% to be valid

Last Name	First Name	Initial	Date of Birth (dd/mm/yy) (if under 18 yrs.)	Relationship to Employee	Percentage (must total 100% or Amount)
Contact Information: Email:			Phone/Cell:		
Contact Information: Email:			Phone/Cell:		
Contact Information: Email:			Phone/Cell:		
Contact Information: Email:			Phone/Cell:		

Contingent Beneficiary(s): if designating percentages, they must equal 100% to be valid

If there are no surviving beneficiaries at the time of my death, I declare that the following Contingent Beneficiary(s) shall receive the proceeds. If there are no surviving Contingent Beneficiary(s) at the time of my death, the proceeds shall be paid to my Estate.

Unless I specify otherwise, my Contingent Beneficiary(s) will apply to all employee benefits which I have coverage. I revoke all previous Contingent Beneficiary(s) appointments.

Last Name	First Name	Initial	Date of Birth (dd/mm/yy) (if under 18 yrs.)	Relationship to Employee	Percentage (must total 100% or Amount)
Contact Information: Email:			Phone/Cell:		
Contact Information: Email:			Phone/Cell:		

Appointment of Trustee: (only required if a named beneficiary is under (18) years of age)

You may wish to appoint a trustee/administrator by completing this section. Please print clearly in **INK**.
If you are designating a trustee/administrator, it is recommended that you consult with a legal advisor and with any proposed trustee/administrator.
I hereby appoint the following trustee/administrator to receive and hold in trust, on behalf of any beneficiary, funds payable to the appointed beneficiary under this group insurance plan where, at the time payment is made, the beneficiary is a minor or otherwise lacks legal capacity. Any such payment will release but not limited to the insurance company or the Administrators of the Plan from further liability.

Last Name	First Name	Initial	Date of Birth (dd/mm/yy) (if under 18 yrs.)	Relationship to Employee	Percentage (must total 100% or Amount)
Contact Information: Email:			Phone/Cell:		

8. PRIVACY

UCCM Anishnaabe Police Service, Target Benefits Administrators and the Insurers recognize and respect the importance of privacy. The personal information collected on this form is necessary to process your application. The information is required in order to ensure your eligibility for the benefit, that the payment of claims is correct, to respond to your questions and for audit purposes. Access to your file is limited to staff or persons authorized by us who require it to perform their duties, to persons to whom you have granted access and to persons authorized by law. The insurers may use service providers located within or outside Canada. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

9. AUTHORIZATION & DECLARATIONS

I authorize:

UCCM Anishnaabe Police Service to deduct the required premiums from my pay;

The use of my payroll number as a unique identification number where it is required to protect employee privacy and confidentiality in the administration of the plan;

The insurers identified on this form, other insurance or reinsurance companies, any health care provider, my plan administrator, administrators of government benefits or other benefits programs, other organizations or service providers to exchange personal information when necessary to determine my eligibility for coverage and to administer my benefit coverage.

If applying for coverage for my spouse and/or my dependent, I certify my insurable interests and I confirm I am authorized to act on their behalf.

I certify that the information given is true, correct and complete to the best of my knowledge.

_____	_____	_____
Signature of Employee	**Print Name**	**Date Signed (mm/dd/yy)**

Original form with inked signature always accepted. Photocopy, facsimile or electronic transmission will be accepted if they include an "INKED" signature. Digital signatures will not be accepted.

Please forward the completed form to:

UCCM Human Resources Administrator

For Inquiries about your benefit coverage:
Target Benefit Administrators- Sarah Krispanis
Phone#: 416-740-1335 ext. 223
Email: sarahk@wlvinc.com

OFFICE USE ONLY: NEW HIRES ONLY

Date of Hire (MM/DD/YY)	**Effective Date of Coverage (MM/DD/YY)**	**Salary$:**	**Payroll ID:**
Signature of Authorized Official		Date (dd/mm/yy)	