

Plan Sponsor Information

Employer/Company Name					
Group No.	Division No.	Unit No.	Certificate No.	Effective Date of Action (dd/mm/yy)	
Action Code			Date of Full-Time Employment (dd/mm/yy)	Date of Full-Time Employment (dd/mm/yy)	Re-Hire Date (dd/mm/yy)
Add ☐	Change ☐	Delete ☐			
Occupation					Regular Hours / Week
Salary Information					
Earnings:	Annually ☐	Monthly ☐	Bi-Weekly ☐	Weekly ☐	Hourly ☐

Plan Member Information

Surname		First Name		Middle Initial	
Address		City or Town		Province	Postal Code
Date of Birth (dd/mm/yy)	Smoker Status		Gender		Language
	Yes ☐	No ☐	Female ☐	Male ☐	Other ☐
					English ☐
					French ☐

Dependant Information

Spouse Information						
Surname	First Name	Date of Birth (dd/mm/yy)	Relationship to Member	Effective Date (dd/mm/yy)	Action Code Add/Change/Delete	Sex Assigned at Birth
						Female ☐
						Male ☐
						Other ☐

Note: For common-law status, the couple must have been cohabitating as defined by the policy(ies) guideline for dependent eligibility. If common-law, please provide date the co-habitation commenced (dd/mm/yy):

Children Information

Surname	First Name	Date of Birth (dd/mm/yy)	Relationship to Member	Effective Date (dd/mm/yy)	Action Code Add/Change/Delete	Sex Assigned at Birth
						Female ☐
						Male ☐
						Other ☐
						Female ☐
						Male ☐
						Other ☐

Relationship to member: Child, Disabled or Over-Age Dependent (If Overage Dependent complete below)

Over-Age Dependent Information (OAD)

Surname	First Name	Date of Birth (dd/mm/yy)	School Start Date	School End Date	School Name (Optional)
				August 31/ ____	
				August 31/ ____	

Note: Coverage for an over-age-dependant terminates on August 31st of each year. If the over-age dependant re-enrolls the next school year, the plan member must re-apply for coverage

Benefit Coverage Information

Member Coverage Status						Spousal Coordination of Benefit Status					
Health			Dental			Health			Dental		
Family ☐	Single ☐	Waived ☐	Family ☐	Single ☐	Waived ☐	Family ☐	Single ☐	Waived ☐	Family ☐	Single ☐	Waived ☐
For Quebec residents aged 65 or over, select the senior ID code: Member: RAMQ ☐ Both ☐ Private ☐ / Spouse: RAMQ ☐ Both ☐ Private ☐											

Spousal Exemption

If you or your dependents are presently covered for Extended Health Care and/or Dental Care benefits under another group contract, you may refuse coverage for such benefit(s) under this contract by selecting the applicable box for each benefit. If you lose spousal coverage, you must apply for coverage within 31 days of the loss of such coverage.

I refuse coverage for myself and my dependents under:

Extended Health ☐

Dental ☐

I refuse coverage for my dependents under:

Extended Health ☐

Dental ☐

Name of Spouse's Benefit Carrier

Effective Date of Spouse's Benefit Coverage (dd/mm/yy)

Beneficiary Designation (for Life and/or AD&D Benefits)

The original of this form will be required for a life claim. If a beneficiary is not assigned, "Estate" will be assumed. Crossed out or corrected beneficiary designations must be initialed. Correction fluid cannot be used. Please print clearly, in Ink.

Beneficiary(ies)

Surname	First Name	Middle Initial	Percentage Allocated	Relationship to Plan Member

For Quebec Residents Only: In Quebec, the designation of your spouse as beneficiary is Irrevocable unless you check the box marked "Revocable" below. If designation is irrevocable, the consent of the Beneficiary is required to change this designation.

I hereby make the above beneficiary designation of my spouse:

☐ **Revocable, I may change this beneficiary designation at any time without the consent of the Beneficiary.**

Minor Clause – Trustee Designation for children under the age of majority:

Name of Trustee	Relationship to Member Insured

If designating a beneficiary who is under the age of majority or who lacks legal capacity you may wish to appoint a trustee/administrator. This appointment may not be suitable for all purposes. If you are designating a trustee/administrator, we recommend you consult with a legal adviser, and with any proposed trustee/administrator.

Privacy Consent

Protecting your personal information:

At ClaimSecure, we're committed to protecting personal information and respecting your privacy. Personal information is information that either on its own or combined with other information allows an individual to be identified. This includes your name and address, as well as more sensitive information such as your health and financial records. When applicable, this includes information about other people such as your spouse, common-law partner, and children.

How we use your personal information:

Your personal information is used to provide you with products and services and to improve our business operations. This includes verifying your identity, maintaining your profile, and informing you about features of the products you already have with us. It's also used to evaluate your eligibility for products, price our products collect feedback on our customer service, process claims, protect you and us from risks such as cyber threats and fraud, and comply with legal obligations. Your certificate number is used to link your products together and to keep your information separate from other customers with similar names.

Who we share personal information with:

We share your personal information with other people and organizations who help us administer your products and provide you with services. This may include your advisor or people who work with your advisor, and other organizations that provide us services such as paramedical examiners, medical laboratories, specialty coverage providers, independent medical examiners, and pharmacies. As well, we may share your information with travel assistance providers, technology suppliers, and insurance or reinsurance companies. As part of our day-to-day business, your personal information may be communicated to government departments and agencies and may be communicated outside your province of residence. We take protecting your personal information seriously and we'll never sell your personal information to anyone.

You're in control of your personal information:

We respect your privacy preferences and follow them when using your personal information. At any point in your relationship with us, you can choose how your personal information is used by submitting a request to our Privacy Office at privacy@claimsecure.com. This includes choosing whether you receive customer experience surveys, and whether you want to receive information and offers from ClaimSecure using the personal information we collect from you throughout your relationship with us. You can also exercise other privacy rights, such as access to or correction of your personal information, by emailing our Privacy Office at privacy@claimsecure.com.

If you choose to remove your consent to the collection, use and disclosure of the personal information required to serve you and meet our legal obligations, we may not be able to continue to provide you with products and services.

ClaimSecure uses personal information when making decisions related to products and services. These decisions may be made using automated processing.

Want to learn more? Please visit <https://www.claimsecure.com/privacy-policy/>.

AUTHORIZATION AND DECLARATIONS

I hereby:

- I designate the person(s) named above under Beneficiary Designation as my beneficiary.
- Authorize ClaimSecure, any healthcare provider, my plan administrator, any insurance or reinsurance company, administrators of government benefits or patient support programs or other benefits programs, other organizations, or service providers working with ClaimSecure or any of the foregoing, located inside or outside Canada, to exchange personal information when relevant and necessary for the adjudication of my claim(s).
- Acknowledge that my personal information will be collected, used, and shared as set out above; and that refusing to consent may result in delay or denial of my request or ClaimSecure not being able to continue to provide me with products and services.

4. Confirm that I am authorized to act on behalf of myself, my spouse and/or dependants when applying for coverage, or for purposes of the ongoing administration of my health and dental benefit plan.
5. Confirm that the information given is true, correct, and complete to the best of my knowledge.

Plan Member Authorization

Signature of Plan Member	Print Name	Date signed (dd/mm/yy)

Plan Sponsor Authorization

Signature of Plan Administrator	Print Name	Date signed (dd/mm/yy)

Please complete form and send to:**E-mail:** eligibilityupdates@claimsecure.com**Fax:** 1-705-673-5968**Or mail:** CLAIMSECURE INC. PO BOX 6500 STN A SUDBURY ON P3A 5N5**Phone:** 1-888-513-4464