

## RETIREE GROUP BENEFITS APPLICATION



Policy No. 160978  
Ambulance/Hospital, Extended Health, Dental

Return completed form no later than **2 weeks prior** to retirement date.

### RETIREE INFORMATION

Surname:		Given Name and Middle Initial(s):		Birth Date (month/day/year):		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Undisclosed	
Address:		City:		Retirement Date (month/day/year):		ID #	
Province:	Postal Code:	Home Telephone: ( )		E-mail Address:			
Name of your Pay & Benefits Specialist (if unsure, please contact your Human Resource department):							
Have you been covered under a Group Health Plan for a minimum of one year prior to date of retirement: <input type="checkbox"/> Yes <input type="checkbox"/> No							

### DEPENDENT INFORMATION (IF APPLICABLE)

SPOUSE							
Surname (if different from Employee Surname):		Given Name and Middle Initial(s):		Birth Date (month/day/year):		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Undisclosed	
<input type="checkbox"/> Legally Married	<input type="checkbox"/> Common Law	If common law, please provide commencement date of cohabitation (month/day/year):					

### UNMARRIED DEPENDENT CHILDREN (Please use back of this page if additional space required.)

Surname (if different from Employee Surname)	Given Name and Middle Initial(s)	Gender				Birth Date (month/day/year)	Full-time Student		Disabled prior age 22	
		Male	Female	Other	Undisclosed		Yes	No	Yes	No
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### GROUP BENEFITS COVERAGE (Coverage and Monthly Premium Rates subject to change)

Benefits Coverage Section	Select only one	Retirees must enroll according to their true family status.		
		Single	Couple	Family
Decline all group benefits coverage offered	<input type="checkbox"/>			
Option 1: Ambulance/Hospital	<input type="checkbox"/>	<input type="checkbox"/> \$17.88	<input type="checkbox"/> \$34.82	<input type="checkbox"/> \$36.37
Option 2: Ambulance/Hospital & Extended Health	<input type="checkbox"/>	<input type="checkbox"/> \$60.58	<input type="checkbox"/> \$110.66	<input type="checkbox"/> \$111.77
Option 3: Ambulance/Hospital & Extended Health & Basic Dental	<input type="checkbox"/>	<input type="checkbox"/> \$91.36	<input type="checkbox"/> \$172.03	<input type="checkbox"/> \$182.57
Option 4: Enhanced Coverage	<input type="checkbox"/>	<input type="checkbox"/> \$157.90	<input type="checkbox"/> \$297.21	<input type="checkbox"/> \$317.82

Retirees may reduce coverage (i.e. switch to a lower option) at any time, but will not be permitted to rejoin after opting out or to upgrade their option. If coverage is declined due to spousal coverage, retirees will be permitted to join when the spousal coverage terminates.

### DECLINE COVERAGE DUE TO SPOUSAL GROUP BENEFIT COVERAGE (IF APPLICABLE)

Decline all group benefits coverage offered due to duplicate coverage through spouse's group benefits plan:	<input type="checkbox"/>
Spousal insurer's name:	Plan number:
<b>If you lose spousal coverage, you must apply for coverage within 60 days of loss of such coverage.</b>	

**BANKING INFORMATION**

Funds can only be withdrawn from either a chequing or savings account. Please attach a copy of a void cheque.

Chequing Account       Savings Account

Branch Transit #: \_\_\_\_\_ Institution #: \_\_\_\_\_ Bank Account #: \_\_\_\_\_

Bank Name: \_\_\_\_\_

Bank Address: \_\_\_\_\_

**AUTHORIZATION**

I hereby apply for coverage under the Retiree Group Benefits Plan as indicated above. I authorize HUB International STRATA Benefits Consulting:

- To automatically debit my bank account for the **monthly premium** as indicated above and remit to Canada Life;
- To exchange personal information, when necessary to determine my eligibility for coverage and to administer the plan.

If applying for coverage for my spouse and/or dependants, I confirm that I am authorized to act on their behalf.

Premium rates are reviewed annually and are subject to change. You will be notified in advance of any changes. I understand that if there are insufficient funds in the account to cover the monthly withdrawal, benefits will cease at the end of the prior month and a fee may be assessed to reinstate coverage and/or may be required to submit medical evidence of good health.

I agree that a photocopy or electronic copy of this application is as valid as the original. I certify that the information given is true, correct and complete to the best of my knowledge.

Retiree Signature: \_\_\_\_\_ Date (month/day/year): \_\_\_\_\_

**Please submit completed form to:**  
**HUB International**  
**Attn: RRC Retiree Benefits**  
**5<sup>th</sup> flr – 1661 Portage Ave.**  
**Winnipeg, MB, R3J 3T7**  
**Telephone: 1-844-984-9456**  
**E-mail: RRCretiree@hubinternational.com**

**OFFICE USE ONLY:**

Employee Number:	Retirement Date (month/day/year):	Entered on GroupNet by:	Division:	Benefit Class:
Retiree Coverage Effective Date (month/day/year):			Date Entered (month/day/year):	