HUMANIA ASSURANCE MD®

Group Insurance Application

Policy N°	Certificate	Effective date D M Y

Employee's family name | **Employee's given name** | Date of birth D M Y | Sex M F

N° **Street** **Apt.** **City** **Province** **Postal Code**

Coverage

☐ **Single** (without dependent) ☐ **Family** (with dependents)

Social Insurance No

Occupation in the company:

Exemption ☐ Medical benefit ☐ Dental Join attestation of insurance

Family coverage (complete this section if you wish to insure your dependents) ☐ Family ☐ Family without spouse ☐ Couple

Spouse | Family and given names | Date of birth D M Y | Sex M F | Commom-law spouse ☐ Date of cohabitation D M Y

Dependents Children (Name and given names) | **Date of birth** D M Y | **Sex** M F

Designation of beneficiary(ies)

Last and first names of beneficiary	Relationship to member	%	Date of birth, if minor DD MM YYYY	Please check
				☐ Revocable ☐ Irrevocable
				☐ Revocable ☐ Irrevocable
				☐ Revocable ☐ Irrevocable

In Quebec, unless a beneficiary is qualified, the beneficiary is irrevocable in the case of a spouse (legal or joined in a civil union), but revocable in all other cases. An irrevocable beneficiary must consent to any change.

Optional benefits (Please check the provisions under your plan. You must complete declaration of insurability).

☐ Optional life **Enter the total amount requested**

☐ EMPLOYEE _____ Amount _____ $ (by $10,000)

☐ ACCIDENTAL DEATH AND DISMEMBERMENT **(Same amount of life insurance)**

To be completed and signed by the plan administrator (employer)

Eligible	**Yes**	**No**
Employment insurance	☐	☐
CSST	☐	☐

Part time ☐ **Full time** ☐

Number of hours of work / week: _____

Date hired Full time D M Y

Eligibility date D M Y

$ Annual salary

Classification

Company name

I certify that the information provided on this application is correct and complete.

Administrator's Name (please print)

Administrator's signature

I hereby authorize any health professional as well as any public or private health or social service establishment, any insurance company, the Medical Information Bureau, financial institutions, personal information officers or security and investigation agencies, risk and claim data agencies, crime and violation prevention, detection or control organizations, market intermediaries, my present or past employers, as well as any public or private organization holding personal information on myself, particularly medical information, to provide to and exchange such information with Humania Assurance Inc. and its reinsurers for purposes of risk assessment or claims investigations and settlements.

In case of my death, I expressly authorize my beneficiary or beneficiaries, heirs or liquidators to supply to Humania Assurance, or to its reinsurers, all the information or authorizations required to process the claim and to obtain supporting documents.

The present consent also applies to the collection, use and communication of personal information on my dependents. A photocopy of this consent has the same value as the original. I acknowledge that I have read the above information. I acknowledge that the coverage provided is subject to restriction or reduction clauses, as well as to the exclusions stated in the policy.

I acknowledge that I have read the notice in relation to the establishment of a personal file (see over). I authorize my employer to deduct the required contributions from my salary and I authorize Humania Assurance Inc., or its reinsurers, to use or communicate my social insurance number for tax and administration purposes.

Signature of employee: _____ **Date :** _____

Original : Humania Assurance • Yellow copy : To keep

NOTICE

To ensure the confidentiality of the personal information held on you, Humania Assurance Inc. will set up an insurance file in wich be entered the information provided on your insurance application, as well as any insurance claim information.

Only those employees or representatives responsible for underwriting, investigating and processing claims or any other person authorized by yourself will have access to this file.

Your file will be kept in the company's offices. You are entitled to consult the personal information contained in this file and to have it rectified, if necessary, by sending a written request to the following address :

Access to Information Officer

Humania Assurance Inc.
1555, Girouard Street West
Saint-Hyacinthe (Quebec)
J2S 2Z6