



# SAMPLE ENROLMENT FORM

- PLEASE PRINT and complete each section clearly in ink.
- Remit a signed original to RWAM and keep a copy for your records.
- Employee must meet all eligibility requirements as noted in the Employee Benefits Booklet.
- You and your dependents must be insured under your Provincial Benefit Plan in order to participate in RWAM's group insurance plan.

Certificate # \_\_\_\_\_

## EMPLOYER DATA

Employer Farmers' Market Inc. Group# RWAM TO ASSIGN Div.# \_\_\_\_\_ Class \_\_\_\_\_  New  Reinstatement

Permanent Full-time Hire Date 2018/01/01 (Reinstatements indicate date of re-hire) (yy/mm/dd) Description of Occupation Store Front / Cashier / Manager / Owner etc.

Earnings \$\$\$ (Excluding Bonus/Dividend/Overtime Income)  Salary (annual)  Bi-Weekly  Weekly  Hourly  Monthly  Bi-Monthly Hours worked 30 (per week)

## EMPLOYEE STATEMENT

Employee's Surname MacDonald First Name Fred

Date of Birth (yy/mm/dd) 1970/01/01 Sex:  Female  Male

Marital Status:  Single  Common-law\*  Separated  Married  Divorced  Widowed  
\* If Common-law, indicate date co-habitation began (yy/mm/dd) \_\_\_\_\_

Address (#, Street, City & PC) 11 Main Street, Halifax NS B2B 1A1

Email - necessary for online claims submissions Fred.MacDonald@gmail.com

SINGLE, Extended Health Care  SINGLE, Dental ⇒ If you are eligible for family coverage your dependents must have coverage\* through your spouse  
Spouse's Employer \_\_\_\_\_  
Spouse's Group Insurance Carrier \_\_\_\_\_  
Please indicate if you have coverage\* through your spouse: E.H.C.  No  Yes  
Dental  No  Yes

FAMILY, Extended Health Care  FAMILY, Dental ⇒ If 'Yes' indicate Spouse's Group Insurance Carrier \_\_\_\_\_  
Claims must be submitted to the primary carrier first. Any portion of the claim not reimbursed by the primary carrier should be sent to the secondary carrier for consideration. Children's claims are reimbursed by the plan of the parent whose date of birth falls first in the calendar year.

WAIVE, Extended Health Care  WAIVE, Dental ⇒ To waive coverage you and your dependents must have coverage\* through your spouse.  
Spouse's Employer \_\_\_\_\_  
Spouse's Group Insurance Carrier \_\_\_\_\_

\* If comparable coverage ceases, you must notify RWAM within 31 days or you will be subject to medical evidence (at your expense) and a one year dental restriction.

## ELIGIBLE DEPENDENTS

	Name (state surname if different than employee's)	Date of Birth (yy/mm/dd)	Relationship to Employee
Spouse	<u>Mary MacDonald</u>	<u>1970/01/01</u>	<u>Spouse</u>
Children*	<u>Mike MacDonald</u>	<u>2017/01/01</u>	<u>Child</u>
	<u>Maryanne MacDonald</u>	<u>2015/01/01</u>	<u>Child</u>
	_____	_____	_____
	_____	_____	_____

\* Students aged 21 or over and under 25 (or as specified in your plan) are only eligible if they submit confirmation of full-time student status.  
\* Children of common-law spouses must reside with the employee to be eligible.

## BENEFICIARY DESIGNATION

I revoke all prior beneficiary designations under this certificate. I hereby designate the following person(s) to receive all group life insurance benefits payable on my death. If more than 1 person is named, proceeds are to be shared equally, unless otherwise stated below. A separate Beneficiary Designation/Change form is required to name contingent beneficiaries.

Beneficiary (ies)	Relationship to Insured	% Shares (must = 100%)	Trustee * If a beneficiary is under age 18: Consider naming a Trustee, as benefits cannot be paid to a minor. Benefits will be paid to the named Trustee (regardless of beneficiary age) unless you change the designation to remove the Trustee.
Name(s) - first & last <u>Mary MacDonald</u>	<u>Spouse</u>	<u>100</u> %	Trustee Name (first & last) _____ As Trustee for (beneficiary name) _____ Relationship to Beneficiary _____
_____	_____	_____ %	_____
_____	_____	_____ %	_____

## AUTHORIZATION

I understand the information I provide on this form will be used by RWAM Insurance Administrators Inc.(RWAM) and the insurer for the purposes of determining eligibility for group insurance coverage and benefits; and to administer benefits under this coverage. I hereby authorize my employer/plan administrator, the authorized group agent/broker, and the insurer to exchange any relevant and necessary information for such purposes. I authorize my employer to deduct from my pay and remit to RWAM any applicable group benefit contributions. If I am applying for coverage for my eligible dependents, I confirm I am authorized to act on their behalf for such purposes. I declare that the statements made on this form are complete and true. I understand that if any statement is incomplete or false, any coverage granted may be voided. This authorization will remain valid for as long as I am claiming benefits or service, or until revoked by myself.

Employee's Signature X Date \_\_\_\_\_ (yy/mm/dd)

## OFFICE USE ONLY

Effective Date	Life Volume <input type="checkbox"/> GF	STD Volume <input type="checkbox"/> GF	LTD Volume <input type="checkbox"/> GF	Extended Health Care <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Nil	Dental <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Nil
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FOR DIRECT DEPOSIT OF BENEFITS COMPLETE REVERSE

RA002\_10.18/RA014\_06.16

RWAM INSURANCE ADMINISTRATORS INC. 49 Industrial Dr., Elmira, ON N3B 3B1 ph. 519-669-1632 1-877-888-7926 fx 519-669-1923



# APPLICATION FOR DIRECT DEPOSIT OF GROUP BENEFIT PAYMENTS

Necessary for online claims submissions

## BENEFITS OF DIRECT DEPOSIT

Direct Deposit of Group Benefit Payments (otherwise known as Electronic Funds Transfer or 'EFT') allows RWAM to deposit your approved benefit payments directly into your personal or joint bank account (your name must be on the account).

You will be e-mailed once your claim is processed, and a corresponding Explanation of Benefits ('EOB') statement will be made available to you, explaining the benefit payment and/or decision.

**Advantages of this convenient service include:** Quick, safe and confidential, eliminates risk of lost or delayed benefit cheques, convenient, no extra trips to the bank, and it's more environmentally friendly.

## EMPLOYEE & BANKING INFORMATION

Employee Name Fred MacDonald Group # RWAM to Assign Certificate # RWAM to Assign

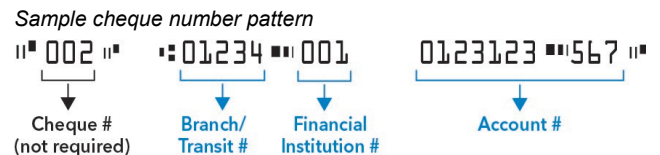
Send my Explanation of Benefits (EOB) to my personal e-mail address at Fred.MacDonald@gmail.com

**Attach Your Cheque Marked "VOID"**  
*If you do not have a chequing account, we recommend that you confirm the account information you are providing with your financial institution.*

Return this form and your VOID cheque by mail, fax or email to:

**RWAM Group Administration Department**  
49 Industrial Drive, Elmira, ON N3B 3B1  
Fax: 519-669-1923  
email: [csr-groupadmin@rwam.com](mailto:csr-groupadmin@rwam.com)

If a void cheque is not included, complete the following:



Name(s) of Account Holder (as it appears on the cheque) Fred MacDonald

Name & Address of Financial Institution Bank of Montreal 123 Main Street, Halifax NS B2B 3A3

Financial Institution # \_\_\_\_\_ (3 digits)      Branch/Transit # \_\_\_\_\_ (5 digits)      Account # \_\_\_\_\_  
(If your Acct. # starts with zero, be sure to include the zero. Do not include dashes, hyphens or any other punctuation.)

- NOTES:**
- If you don't have cheques and are unfamiliar with how to complete the above, contact your financial institution or your Plan Administrator to make sure you are providing RWAM with the correct information. Inaccurate or missing information can result in delays or errors.
  - You must be the sole or **joint** (generally jointly with your spouse) account holder at a Canadian financial institution & have signing authority.
  - Applications for deposit to a third party's account will be rejected.

## AUTHORIZATION

I hereby authorize RWAM Insurance Administrators Inc. to deposit Group Benefits (Extended Health, Dental and/or Disability) payments directly to my personal/joint bank account and to exchange my relevant financial information with my financial institution for such purposes. This authorization shall remain valid until revoked by me in writing. Any copy of this authorization shall be as valid as the original.

Employee Signature x Date (yy/mm/dd) \_\_\_\_\_

