Equitable Life of Canada®

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NEW PLAN MEMBER GROUP INSURANCE APPLICATION

SECTION A

PLAN SPONSOR

This section to be completed by the Plan Sponsor or Group Plan Administrator/Insurer

Name of Policyholder

Name of Division/Subsidiary or Affiliate where the Plan Member works

Group Policy Number | Division Number | Class

Plan Member's Name (First) | (Middle) | (Last) ☐ Male ☐ Female

Certificate Number | Occupation

Health Care Spending Account (HCSA) starting balance _____
(If different from Standard allocation) $_____

Date Employed Full time (MM/DD/YYYY)

Earnings: $_____ ☐ Hour ☐ Week ☐ Month ☐ Year ☐ Other_____

If hourly earnings – standard hours worked per week: _____ Billing Sort Code (If applicable): _____

SECTION B

PLAN MEMBER

This section to be completed by the Plan Member

Plan Member's Date of Birth (MM/DD/YYYY)

Plan Member's email address _____

Plan Member's address:

Street | City | Province | Postal Code

Preferred Language: ☐ English ☐ French

Marital Status: ☐ Married ☐ Single ☐ Common Law* ☐ Widow(er) ☐ Divorced ☐ Separated

Number of Dependent Children: _____

* If Common-law status, when did you begin living together as partners? _____ (MM/DD/YYYY)

SECTION C

PLAN MEMBER

This section to be completed by the Plan Member

1. I need ☐ Health ☐ Dental for myself only, as I have no eligible dependents (Single Coverage)
*2. I need ☐ Health ☐ Dental for myself only, as my spouse/partner and/or children have coverage as noted below
3. I need ☐ Health ☐ Dental for myself and my family (Family Coverage)
*4. I need ☐ Health ☐ Dental for myself and my family; and my spouse/partner and/or children also have coverage as noted below (Coordination of Benefits)
*5. I do not need ☐ Health ☐ Dental as I am covered through my Spouse's/Partner's plan as noted below (Forfeiture of coverage)

*Does your spouse/Partner have Group coverage elsewhere? ☐ Yes ☐ No if "Yes", you must complete the following information:
My Spouse/Partner and children have coverage through: _____
Name of Insurance Carrier or or name of employer

If you choose options *2, *4 or *5, you must provide information about your spouse/partner's coverage.

I understand that I can join the Health/Dental plan with Equitable Life if I apply within 31 days of the termination of my spouse's/partner's coverage with his/her Employer. If I apply more than 31 days after the termination of my spouse's/partner's coverage, evidence of insurability will be required, and Dental coverage will be restricted. If I and/or my dependents have no current Group coverage, I understand I/we can apply in the future only with satisfactory evidence of insurability and coverage may be restricted or denied.

SECTION D

PLAN MEMBER

Spouse/Partner/ Children details

This section to be completed by the Plan Member

This information is required if your Group Plan includes Dependent Life and/or you are applying for Family Health and Dental Coverage and/or you have Health Connector services.

Full Name of Spouse or Partner (Common Law): (first, middle, last)	☐ Male ☐ Female	Date of Birth: (MM/DD/YYYY)	
Full Name of Child: (first, middle, last)	☐ Male ☐ Female	Date of Birth: (MM/DD/YYYY)	☐ Disabled or ☐ Student
Full Name of Child: (first, middle, last)	☐ Male ☐ Female	Date of Birth: (MM/DD/YYYY)	☐ Disabled or ☐ Student
Full Name of Child: (first, middle, last)	☐ Male ☐ Female	Date of Birth: (MM/DD/YYYY)	☐ Disabled or ☐ Student
Full Name of Child: (first, middle, last)	☐ Male ☐ Female	Date of Birth: (MM/DD/YYYY)	☐ Disabled or ☐ Student
Full Name of Child: (first, middle, last)	☐ Male ☐ Female	Date of Birth: (MM/DD/YYYY)	☐ Disabled or ☐ Student

Children age 21 or older must be registered as a full-time student or qualify as a disabled Dependent.

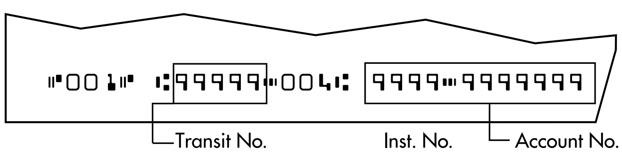
SECTION E

PLAN MEMBER

This section to be completed by the Plan Member

I authorize Equitable Life to deposit Group Claim payments directly into my bank account.

Bank's Name:	
Bank's Address:	
Bank's Phone Number:	Account Number:
Institution Code:	Bank Transit Number:



Your transit number will be either 4 or 5 digits.

Transit No.	Inst. No.	Account No.
	0 0 4	

Please attach a VOID cheque or Stamped bank document to process your direct deposit.

SECTION F

PLAN MEMBER

This section to be completed by the Plan Member

Confirmation of Provincial Health Plan Coverage

I am covered for Provincial Health Plan: ☐ Yes ☐ No

If no, date your Provincial Health coverage will be in effect ______________________ (MM/DD/YYYY)

My Dependents are covered under the Provincial Health Plan: ☐ Yes ☐ No

If no, date your dependents' Provincial Health coverage will be in effect ______________________ (MM/DD/YYYY)

Confirmation of Provincial Drug coverage for residents of British Columbia, Manitoba and Saskatchewan only:
In order to ensure that you have access to the maximum prescription drug coverage available, you are required to register for your Provincial drug coverage program.

Are you registered for one of these Provincial drug programs? ☐ Yes ☐ No
If Yes, Equitable Life requires a copy of your Provincial Ministry letter or document that provides proof of registration. Please attach a copy of your proof of registration to this enrolment form.

Please see page four, section F of this form for additional information.

SECTION G

PLAN MEMBER

This section to be completed by the Plan Member

NOTE: If no beneficiary is appointed, the proceeds shall be paid as required by provincial law. If more than one beneficiary is appointed, proceeds will be payable in equal shares, unless otherwise indicated. The insured Plan Member can change the appointed beneficiary at any time.

Name of Primary Beneficiary (first, middle, last)	☐ Male ☐ Female	Relationship to Plan Member:	% Share
Name of Primary Beneficiary (first, middle, last)	☐ Male ☐ Female	Relationship to Plan Member:	% Share

If the above Primary Beneficiary(ies) pre-deceases me, to:

Name of Contingent Beneficiary (first, middle, last)	☐ Male ☐ Female	Relationship to Plan Member:	% Share
Name of Contingent Beneficiary (first, middle, last)	☐ Male ☐ Female	Relationship to Plan Member:	% Share

NOTE: If both the Primary Beneficiary(ies) and Contingent Beneficiary(ies) are deceased, the proceeds will be paid as required by provincial law. If there are additional Primary and/or Contingent Beneficiaries, please sign, date and attach a note to this form with the beneficiary information.

NOTE: For Quebec residents, designating your spouse as beneficiary is irrevocable unless you make the designation revocable. An irrevocable beneficiary designation cannot be changed without the written consent of the irrevocable beneficiary. A revocable beneficiary designation can be changed at any time without the consent of the revocable beneficiary. I elect to make my spouse (married or civil union) designation: ☐ Revocable

If the beneficiary is under the age of majority at the time of my death, proceeds of the said policy shall be payable to the following:

Name of Trustee _____ ☐ Male ☐ Female
(Please Print - First, Middle, Last)

Relationship to Plan Member _____

The personal information willingly provided by me to my Plan Sponsor, the independent broker/sales advisor and/or Equitable Life, collected on this Application and held in their files, will be used by Equitable Life for the purposes of underwriting, servicing, administration, claims processing and adjudication related to this Application, the Group Insurance Policy and all benefits there under, and any supplementary documents. I understand and authorize that for the above purposes the personal information on file is accessible to, and may be exchanged with, authorized employees of, and relevant third parties retained by Equitable Life, any industry drug pooling entity, its sales distribution network, participating reinsurer(s), other insurance companies, investigative organizations, health care providers, including, but not limited to pharmacies, physicians and dentists and any other person or party whom I authorize. If applying for my spouse and/or dependents, I confirm that I am authorized to act on their behalf and therefore this consent and authorization also applies to the collection, use and communication of their personal information for the same purposes. I understand that all claims made under the Group Insurance Policy are submitted through me as insured Plan Member. I therefore authorize Equitable Life to exchange information about these claims with me or any person acting on my behalf, including a spouse or dependent, as deemed necessary for the purposes of confirming eligibility and assessing and managing the claim.

I certify that all of the information given on this form is true, correct and complete.
I authorize use of my Social Insurance Number (S.I.N.) for identification purposes and designate the beneficiary(ies) stated above.

Date: _____ Plan Member's Signature: _____
(MM/DD/YYYY)

IMPORTANT NOTE:

Please keep a copy of this Application for your records. Please follow these instructions carefully.

Incorrect or incomplete information will result in denial or improper payment of your claims. For the purposes of the Group Insurance Policy,

"Spouse" means: a) the legally married husband or wife of the Plan Member, or
b) a person of the same or opposite sex who resides with the Plan Member in a conjugal relationship and is publicly represented as the partner of the Plan Member.

"Dependent" means a spouse as defined above, and/or your natural child, adopted child, stepchild and child you have been granted final guardianship or custody of by an order of the Court, normally residing with you or your spouse.

Section A: To be completed by the Plan Sponsor. Please print.
Please note: information may be inserted by the insurer for data verification purposes. For plans with Health Care Spending Accounts, indicate the Plan Member's opening HCSA balance, if balance is different from your Group Policy's Standard Allocation.

Section B: To be completed by the Plan Member. Please print.

Section C: To be completed by the Plan Member. Please print.
How to choose Health and/or Dental Benefits

1) If you require Single Health and/or Dental coverage because you have no eligible dependents, select Option 1, for Single Coverage
2) If your spouse and/or children are covered for Health and/or Dental benefits through another plan, but you want coverage for yourself only from Equitable Life, select Option 2, for Single Coverage with Forfeiture. Provide the name of your spouse's/partner's insurance carrier where indicated.
3) If you require coverage for yourself and your dependents, select Option 3, for Family Coverage.
4) If you choose family coverage and your spouse/partner has coverage elsewhere, select Option 4 to coordinate benefits with the other plan.

Benefits: You can submit claims under one plan and submit any remaining unpaid amounts to the other plan.
NOTE: Canadian Life and Health Insurance Association Regulations Stipulate:

- A spouse/partner must submit claims to his/her own plan First.
- Claims for insured children must first be submitted to the plan insuring the spouse/partner whose month of birth is the earliest in the calendar year. If both spouses/partners were born in the same Month, the earlier Day would apply.
  Provide the name of your spouse's/partner's insurance carrier where indicated.

Section D: To be completed by the Plan Member. Please print. This information is required if your group Plan includes Dependent Life and/or if you are applying for Family Health and/or Dental Coverage.

- Indicate the names and dates of birth of all eligible dependents. Please confirm the accuracy of the birth dates, since errors will affect claim payments and dependent eligibility.
- If you have more than 5 dependent children, provide additional information below.
  If your child is a Student whose age is between 21 years and your Group Plan's maximum age for dependents, proof of full-time student status is required. Please complete form 441 - Application for Coverage of Dependent Child Over Age 21.
  Disabled Dependents age 21 and older may be eligible for coverage if certain conditions, as established by Equitable Life, are met. Form 441 - Application for Coverage of Dependent Child Over Age 21, along with an Attending Physician's letter must be received by Equitable Life prior to the Disabled Dependent's 21st birthday.

Section E: To be completed by the Plan Member. Please print.
By providing your banking information and VOID cheque, you are authorizing Equitable Life Insurance company of Canada to deposit Group Claim Payments directly into your bank account.

Section F: To be completed by the Plan Member. Please print.
Please indicate here whether you and/or your dependents are covered for the provincial health plan in your province of residence.
If you reside in British Columbia, Manitoba or Saskatchewan, you are required to register for your Provincial drug coverage Program.

If not covered by the provincial health plan, please indicate the date on which you will be covered.
Please note that if you are not registered, you may receive a reminder from Equitable Life about the requirement to register.
If you do not register (or provide proof of registration) after receiving a reminder, your drug claims may be declined.
For more information on Provincial prescription drug support programs, including how you register, or confirm that you are registered, please visit:

- For British Columbia residents: https://pharmacare.moh.hnet.bc.ca
- For Manitoba residents: http://www.gov.mb.ca/health/pharmacare/index.html
- For Saskatchewan residents: http://formulary.drugplan.health.gov.sk.ca

Section G: To be completed by the Plan Member. Please print.
Beneficiary Designations:

- Indicate the full name an relationship of the Beneficiary(ies) to you in the space(s) provided.
- You have the right to change the Beneficiary at any time; however, where Quebec law applies, the beneficiary designation for your spouse must be designated as revocable to reserve this right.
- If more than one Beneficiary is appointed, proceeds will be payable in equal shares, unless you indicate otherwise.
- If the appointed Beneficiary is under the age of majority, a Trustee of legal age must be appointed. If a Trustee is not appointed, proceeds will be paid as required by provincial law. The full name of the Trustee and relationship to you are required.

NOTE: You cannot appoint yourself as Beneficiary or Trustee.