GROUP ENROLMENT FORM

MDM INSURANCE SERVICES INC.

Privacy Statement

MDM Insurance Services Inc. is committed to protecting the privacy, confidentiality, accuracy, and security of the personal information that it collects, uses, retains, and discloses in the course of conducting business. We will not disclose your information to a 3rd party without your personal and prior approval.

A. PERSONAL INFORMATION

Last name: First name: Initial:

Home mailing address: _____
Street City Prov. Postal Code

Date of birth: YR _____/ MO _____/ DAY _____ ❒ Male ❒ Female ❒ Single ❒ Married ❒ Common-law* ❒ Other _____

e-mail address: Language preference: ❒ English ❒ French

Banking information: | | | | | | | | | | | | | | | | | | | | | | | |
bank # transit # account #

*Common-law declaration: *I have been living with and representing _____ as my spouse since _____ (Y/M/D). My common-law spouse and I are solely responsible financially for all our children claimed for insurance purposes. I further verify that I am not obliged to provide coverage for my legal spouse, if any.*

B. COVERAGE REQUIRED

Extended Health Care: ❒ Single ❒ Family ❒ Waived - *I am opting out as I and my dependents have Extended Health Care benefits under my spouse's plan. I understand that I have 31 days after the termination of my spouse's plan to apply for Extended Health Care benefits under this policy, or I and/or any eligible dependents will be required to furnish at my own expense, evidence of insurability satisfactory to the insurance company.*

Dental: ❒ Single ❒ Family ❒ Waived - *I am opting out as I and my dependents have Dental benefits under my spouse's plan. I understand that I have 31 days after the termination of my spouse's plan to apply for Dental benefits under this policy, or I and/or any eligible dependents will be restricted to first year benefit limits as outlined in the group policy.*

Co-ordination of Benefits (COB): Are you or your dependents currently covered under another group medical insurance policy?* ❒ Yes ❒ No
Are you or your dependents currently covered under another group dental insurance policy?* ❒ Yes ❒ No

* If the other policyholder is someone other than a dependent listed below, please provide:

Last Name_____ First Name_____ Date of Birth_____

C. DEPENDENT ENROLMENT *** THIS MUST BE COMPLETED FOR ALL DEPENDENT COVERAGES ***

Dependent	Last Name	First Name	Date of Birth (yy/mm/dd)	EHC COB	Dental COB	Is the Employee the Custodial Parent?	Gender
Spouse				❒ Y ❒ N	❒ Y ❒ N		❒ M ❒ F
Child				❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N	❒ M ❒ F
Child				❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N	❒ M ❒ F
Child				❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N	❒ M ❒ F

D. BENEFICIARY DESIGNATION

Primary Beneficiary (ies) - equal shares unless other % indicated	Relationship	% Share
Contingent Beneficiary (ies) - equal shares unless other % indicated	Relationship	% Share

If a beneficiary is a minor, designate a Trustee: _____ Relationship to Employee: _____

E. EMPLOYEE SIGNATURE AND AUTHORIZATION

I hereby apply for group benefits coverage and authorize the deduction from my pay and remittance to MDM Insurance Services Inc. any contributions required under the group benefits plan. I hereby authorize my employer, MDM Insurance Services Inc., the group plan administrator, their agents, or any other person or organization having any relevant information regarding me, my spouse or dependents to release and exchange any and all information necessary for the purposes of determination of eligibility for benefits and administration of the group benefits plan. I confirm I am authorized to act on behalf of my spouse and/or dependents for such purposes. I declare that the information provided is true, complete and accurate. Any copy of this authorization shall be as valid as the original.

Signature: _____ Date: _____

F. EMPLOYMENT INFORMATION - to be completed by employer

Employer Name: Group #: Class/Location #:

Full-time employment commenced (Y/M/D): Part-time employment commenced (Y/M/D):

Minimum hours worked each week: Occupation:

Present Salary: $_____ ❒ Hourly ❒ Weekly ❒ Bi-weekly ❒ Monthly ❒ Annually

To elect to Waive the Waiting period for this employee see the reverse side for instructions (Section F; #4)

I confirm that this enrollee has been continuously in our employ since the date given and is at present working actively with pay.

Signature: _____ Title: _____ Date: _____

ENROLMENT FORM INSTRUCTIONS

Please clearly print all information in ink.

SECTION A - PERSONAL INFORMATION (to be completed by the employee)

1. Clearly print your name and full mailing address including postal code.
2. Enter date of birth in year, month, day format and mark an "x" to indicate gender and family status.
3. Enter your e-mail address and banking information if you wish your claims to be processed electronically. Your bank account will be automatically credited in the amount of your claim. An Explanation of Benefits will be sent to you via e-mail.
4. Complete the common law declaration if applicable with the name of your common law spouse and date of cohabitation.

SECTION B - COVERAGE REQUIRED (to be completed by the employee)

1. For Extended Health Care and Dental check the appropriate coverage box. Indicate if coverage for you or your dependents is also available from another source (co-ordination of benefits). If the other policyholder is someone other than a listed dependent, please indicate their full name and date of birth.
2. If you are eligible for coverage through your spouse's plan and choose to waive Extended Health Care and/or Dental coverage, please check the appropriate box.

SECTION C - DEPENDENT ENROLMENT (to be completed by the employee)

1. Print last and first name of each person eligible to be covered under your employer's benefit plan. Attach separate sheet if additional space is required.
2. Enter the full birth date in year, month, day format for each dependent. Please ensure the accuracy of birth dates as it will affect claims payment and dependent eligibility.
3. For each listed dependent, indicate if co-ordination of benefits is applicable for EHC and/or dental.
4. If you and your spouse are separated/divorced, please indicate whether you are the custodial parent.
5. Indicate gender of dependent.

SECTION D - BENEFICIARY DESIGNATION (to be completed by the employee)

1. In the event the Primary Beneficiary(ies) predeceases the employee, the Contingent Beneficiary(ies) shall be entitled to the benefits. Where all beneficiaries predecease the employee, benefits shall be paid to the employee's estate.
2. If more than one beneficiary is listed, benefits will be paid in equal shares unless other percentages are provided.
3. Policy proceeds cannot be paid to a minor. If a minor is named as a beneficiary, you must name a trustee. If naming a trustee, you may want to consider creating a trust agreement or referencing an existing trust agreement.

SECTION E - EMPLOYEE SIGNATURE AND AUTHORIZATION (to be completed by the employee)

This form must be signed and dated by the employee.

SECTION F - EMPLOYMENT INFORMATION (to be completed by the employer)

1. Employer Name (Please print).
2. Date full-time employment and/or date part-time employment commenced.
3. Indicate minimum weekly hours enrollee works and employee's occupation.
4. If you elect to apply to waive the Waiting Period for this employee, a completed Application to Waive Waiting Period form must be completed by an authorized representative of the Employer and accompany this form or be received within 31 days of the employee's eligibility to join the plan. If you elect to apply to waive the Waiting Period, you must do so in its entirety.
5. Record employee's present salary and check the appropriate rate of pay coincident with salary.
6. Sign and date.

TO AVOID DELAYS, PLEASE ENSURE ALL REQUIRED INFORMATION IS PROVIDED.

SEND COMPLETED ENROLMENT FORM TO:

MDM Insurance Services Inc.
P.O. Box 970
Guelph, Ontario N1H 6N1