University of Lethbridge

THE UNIVERSITY OF LETHBRIDGE
GROUP INSURANCE APPLICATION FORM

Please complete and sign this form and return to Pension and Benefits. You may wish to retain a copy for your records. Please keep Pension and Benefits informed of any changes in your family status (i.e. change of beneficiary, new dependents).

☐ Initial Enrollment _____ Effective Date

☐ Change _____ Effective Date

EMPLOYEE DATA

_____ Employee Last Name | _____ First Name | _____ Middle Initial | _____ Date of Birth Day/Month/Year | _____ Province of Residence

_____ Employee I.D. # | _____ Employee Contract Group (AUPE, Faculty, etc.) | ☐ Continuing ☐ Term | _____ Current Hire Date

☐ Male ☐ Female

Type of Extended Health Coverage: ☐ Single ☐ Family

Type of Dental Coverage: ☐ Single ☐ Family

BENEFICIARY INFORMATION

If you have more than one beneficiary, please list beneficiaries, by benefit, on a separate page.

Basic Life:

Beneficiary:

_____ Last Name | _____ First Name | _____ Middle Initial | _____ Relationship

Contingent Beneficiary (in the event of the Beneficiary's death):

_____ Last Name | _____ First Name | _____ Middle Initial | _____ Relationship

if living, otherwise to my estate, except that, if more than one beneficiary is named, the proceeds shall be paid to the surviving beneficiaries or beneficiary.

TRUSTEE CLAUSE if appointing a Minor Beneficiary, please complete this Trustee Clause. I hereby nominate and appoint:

_____ (Last Name) _____ (Given Names in full) MY _____ Relationship to Employee

if living, to receive and disburse any moneys payable under the said group policy to my beneficiary(ies) during minority, and any payments made to the said trustees shall discharge UNIVERSITY OF LETHBRIDGE BENEFITS CARRIER to the extent of such payment.

Optional Life:

Beneficiary:

_____ Last Name | _____ First Name | _____ Middle Initial | _____ Relationship

Contingent Beneficiary (in the event of the Beneficiary's death):

_____ Last Name | _____ First Name | _____ Middle Initial | _____ Relationship

if living, otherwise to my estate, except that, if more than one beneficiary is named, the proceeds shall be paid to the surviving beneficiaries or beneficiary.

TRUSTEE CLAUSE if appointing a Minor Beneficiary, please complete this Trustee Clause. I hereby nominate and appoint:

_____ (Last Name) _____ (Given Names in full) MY _____ Relationship to Employee

if living, to receive and disburse any moneys payable under the said group policy to my beneficiary(ies) during minority, and any payments made to the said trustees shall discharge UNIVERSITY OF LETHBRIDGE BENEFITS CARRIER to the extent of such payment.

Accidental Death and Dismemberment:

Beneficiary:

_____ Last Name | _____ First Name | _____ Middle Initial | _____ Relationship

Contingent Beneficiary (in the event of the Beneficiary's death):

_____ Last Name | _____ First Name | _____ Middle Initial | _____ Relationship

if living, otherwise to my estate, except that, if more than one beneficiary is named, the proceeds shall be paid to the surviving beneficiaries or beneficiary.

TRUSTEE CLAUSE if appointing a Minor Beneficiary, please complete this Trustee Clause. I hereby nominate and appoint:

_____ (Last Name) _____ (Given Names in full) MY _____ Relationship to Employee

if living, to receive and disburse any moneys payable under the said group policy to my beneficiary(ies) during minority, and any payments made to the said trustees shall discharge UNIVERSITY OF LETHBRIDGE BENEFITS CARRIER to the extent of such payment.

REQUIRED FAMILY INFORMATION FOR EXTENDED HEALTH AND DENTAL BENEFITS

Last Name	First Name and Initial	Date of Birth Day Month Year	Gender	Indicate Re/Code**
				N/A
Spouse				
1st Child				
2nd Child				
3rd Child				
4th Child				
5th Child				

** Relationship Code

1. Dependent (under age 21)
2. Dependent (under age 25 and full-time student)
3. Disabled Dependent

CO-ORDINATION OF BENEFITS

Co-ordination of benefits is a method used by the insurance industry to determine the order of paying benefits when the spouse and children are covered under more than one group insurance plan. For example, a spouse who is covered under his/her employer's plan must submit claims under that employer's plan first. Claims for dependents are submitted under th plan of the parent with the earlier day and month of birth in the calendar year.

By ensuring that claims for dependents are submitted to the appropriate employer plan, you will assist The University of Lethbridge in containing costs under the Extended Health and Dental Plans.

Does your spouse have Extended Health coverage under another group plan? Yes ☐ No ☐

If yes, ☐ Single coverage, or ☐ Family coverage

Does your spouse have Dental coverage under another group plan? Yes ☐ No ☐

If yes, ☐ Single coverage, or ☐ Family coverage

If yes, _____ Spouse's Employer _____ Spouse's Insurance Company

OPTING OUT DUE TO DUPLICATE EXTENDED HEALTH AND/OR DENTAL BENEFITS

If you are covered for similar benefits under another plan, you may choose to opt out of the University of Lethbridge Extended Health and/or Dental benefits for yourself and/or your dependents.

1. I wish to opt out of Extended Health benefits for: ☐ Myself and my dependents ☐ My dependents
2. I wish to opt out of Dental benefits for: ☐ Myself and my dependents ☐ My dependents

Spouse's Employer	Spouse's Insurance Company	Policy No.	Spouse's I.D. No.

In the event the other coverage (as noted above) is discontinued, I agree to notify Pension and Benefits and to become covered under the group policy carried by the University of Lethbridge for the above waived benefit(s), within 31 days of the end of the other coverage. I understand that if I do not, I will have to provide medical evidence of insurability to be covered at any later date. If I am approved for Dental coverage as a late applicant, I understand certain benefits will be limited in the initial years of coverage.

_____ Employee Signature _____ Date

EMPLOYEE AUTHORIZATION

I hereby apply for insurance under the group policy carried by the University of Lethbridge subject to all the terms, conditions and provisions of said policy. The foregoing answers are, to the best of my knowledge and belief, true, complete and correctly recorded. If a contribution towards the premium is required, I authorize the necessary deductions from my earnings.

Employee Signature _____ Date _____

The personal information collected on this form is subject to the provisions of the Alberta Freedom of Information and Protection of Privacy Act (FOIPP) and is collected for the purpose of administering benefit/pension programs for employees. Information collected may be forwarded to the corresponding institutions for the purpose of administering the programs. If you have any questions about the collection of this information, contact Human Resources, University of Lethbridge, 4401 University Drive, Lethbridge, Alberta, T1K 3M4, phone 329-2274.