

JAN-WEST EMPLOYEE BENEFITS LTD.

Group Benefit Enrollment Form –Page 1 of 2 (PLEASE PRINT)

Original Required

LANGUAGE English French

SIN/Certificate No.

COVERAGE APPLIED FOR – per Plan Design

<input checked="" type="checkbox"/> Basic Life	<input type="checkbox"/> Dependent Life	<input type="checkbox"/> Weekly Indemnity	EHC	<input type="checkbox"/> Single	<input type="checkbox"/> Family	<input type="checkbox"/> Waive (see Sec. VI)	Effective Date (mo/da/yr)
<input checked="" type="checkbox"/> Basic AD&D	<input type="checkbox"/> Dependent AD&D	<input type="checkbox"/> Long-Term Disability	DEN	<input type="checkbox"/> Single	<input type="checkbox"/> Family	<input type="checkbox"/> Waive (see Sec. VI)	/ /
For ALL members w/ Dependents (automatically enrolled)							Note: <i>waiting period</i>

Optional Benefits: Please ask your administrator for more information.

POLICY INFORMATION

Policy No. **25800** Policy Name **INSURANCE BROKERS ASSOCIATION OF BC**

I. PERSONAL INFORMATION

Participant's Family Name Given Name(s) (abbreviate if necessary)
Initial

Main Residence No., Street Municipality

Province Postal Code

BRITISH COLUMBIA

Date of birth (Y/M/D) Sex

Male Female

Marital Status

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IV. DEPENDENT INFORMATION

TIPS

- The given name, sex and date of birth of each participant's dependents must be entered.
 In the case of

Spouse	Last Name(s)	Date of birth (Y/M/D)	
	Given name(s)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Child	Last Name(s)	Date of birth (Y/M/D)	
	Given name(s)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Child's status <input type="checkbox"/> Student <input type="checkbox"/> Disabled
Child	Last Name(s)	Date of birth (Y/M/D)	
	Given name(s)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Child's status <input type="checkbox"/> Student <input type="checkbox"/> Disabled
Child	Last Name(s)	Date of birth (Y/M/D)	
	Given name(s)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Child's status <input type="checkbox"/> Student <input type="checkbox"/> Disabled

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SIN/Certificate No.

POLICY INFORMATION

Policy No. **25800**

Policy Name **INSURANCE BROKERS ASSOCIATION OF BC**

I. PERSONAL INFORMATION

Participant's Family Name

Given Name(s) (abbreviate if necessary)

Initial

Company

Division

OPTIONAL BENEFITS (LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT [A.D.&D.]

TIPS

I wish to obtain Optional Benefits: Yes No

- [Optional Benefits](#) (PDF - 21K)
- [Evidence of Insurability](#) (PDF - 24K)

This section is only displayed if the contract provides these benefits for participants and / or dependents.

Participants who apply for optional benefits must submit a duly completed and signed *Evidence of Insurability form - G1053*, unless plan provisions allow participants to obtain coverage without evidence of insurability.

Participant Statement: Have you smoked cigarettes or small cigars (cigarillos) during the past 12 months?

Yes No

Amount of insurance (according to the conditions of your policy)

Total amount: \$

A.D.&D.: Total amount: \$

The beneficiary for the Optional Benefits is the same beneficiary as for the Life Insurance Benefits.

Spouse Statement: Has your spouse smoked cigarettes or small cigars (cigarillos) during the past 12 months?

Yes No

Amount of insurance (according to the conditions of your policy)

Total amount: \$

A.D.&D.: Total amount: \$

Beneficiary: The participant is the beneficiary of the spouse's Optional Life and A.D. & D. insurance.

Dependent Children Amount per child (according to the conditions of your policy)

Total amount: \$

A.D.&D.: Total amount: \$

Beneficiary: The participant is the beneficiary of the dependents' Optional Life and A.D. & D. insurance.