INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.
www.inalco.com

Quebec and Atlantic Provinces
PO Box 790, Station B
Montreal, Quebec H3B 3K6

Ontario and Western Provinces
522 University Avenue
Toronto, Ontario M5G 1Y7

Group INSURANCE

ENROLMENT REQUEST

Please print in ink and sign.

❑ **New application** ❑ **Reinstatement**

TO BE COMPLETED BY THE PLAN ADMINISTRATOR

Policyholder's name (Employer/organization) Ontario Harness Horse Association **Group policy no.** 23316

Division no. ____ Class no. ____ Location ____ Certificate no. ____

Employment date: Y M D

Eligibility date: Y M D

If the period between the employment date and the eligibility date is different from the waiting period in your plan, please explain why: ____

Member's occupation ____

Salary $ ____ ❑ Weekly ❑ Annually ❑ Bi-weekly ❑ Monthly ❑ Hourly - Hours worked/week: ____

COMPLETE THE FOLLOWING SECTION TO REINSTATE A MEMBER:

Date previous employment ended Y M D Date rehired on a full-time basis Y M D

Additional information ____

Authorized signature ____ Date ____

TO BE COMPLETED BY THE MEMBER

1. MEMBER INFORMATION

Last name ____ First name ____

Date of birth Y M D Language ❑ English ❑ French Sex ❑ Male ❑ Female

Marital status ❑ Single ❑ Divorced/Separated ❑ Married/Civil union ❑ Common-law – Since Y M D ❑ Other

Address ____
Street City Province Postal code

2. DEPENDENT'S COVERAGE *(Complete to obtain coverage for your dependents)*

Last name	First name	Sex	Date of birth	If age 21 or over, specify:
Spouse		❑ M ❑ F		
Child		❑ M ❑ F		Full-time student ❑ Yes ❑ No Handicapped ❑ Yes ❑ No
Child		❑ M ❑ F		Full-time student ❑ Yes ❑ No Handicapped ❑ Yes ❑ No
Child		❑ M ❑ F		Full-time student ❑ Yes ❑ No Handicapped ❑ Yes ❑ No

3. COORDINATION AND WAIVER OF BENEFITS *(Complete only if you and/or your dependents are covered for similar benefits under another plan)*

Coordination of benefits (Check the appropriate boxes)

Coverage under your spouse's plan

Health: ❑ Individual ❑ Family ❑ Waived (no coverage)

Dental: ❑ Individual ❑ Family ❑ Waived (no coverage)

Waiver of benefits (Check the appropriate boxes to decline coverage for yourself and/or your family members)

❑ Waiver of member's coverage
- ❑ Health insurance
- ❑ Dental care insurance

❑ Waiver of dependent's coverage
- ❑ Health insurance
- ❑ Dental care insurance

Spouse's name ____ Spouse's group policy no. ____ Spouse's certificate no. ____

Spouse's insurance company ____ Spouse's employer ____

If you waive coverage and wish to request it at a later date, certain conditions may apply.
Please contact your plan administrator for further details.

YOU MUST COMPLETE AND SIGN THE *MEMBER CONFIRMATION/AUTHORIZATION* ON THE REVERSE SIDE.

4. OPTIONAL BENEFITS *(Check with your plan administrator if optional benefits are offered in your group insurance contract and if an additional form is required)*

	LIFE	AD&D	CRITICAL ILLNESS	STATEMENT
Member	$_____	$_____	$_____	In the past 12 months, have you smoked or used cigarettes, cigarillos, cigars, pipe, chewing tobacco, nicotine gum or patches or any other tobacco product? ❑ Yes ❑ No **Member's signature** X_____
Spouse	$_____	$_____	$_____	In the past 12 months, have you smoked or used cigarettes, cigarillos, cigars, pipe, chewing tobacco, nicotine gum or patches or any other tobacco product? ❑ Yes ❑ No **Spouse's signature** X_____
Child	$_____	$_____	$_____	

5. BENEFICIARY DESIGNATION *(If no beneficiary is designated by the member then the benefit is payable to the estate)*

Last name	First name	Relationship	%	Date of birth	
					❑ Revocable ❑ Irrevocable
					❑ Revocable ❑ Irrevocable

In Quebec, if you do not indicate whether the beneficiary designation is revocable or irrevocable, the designation of the legal spouse is irrevocable and any other choice is revocable.

The above beneficiary designation applies to the member's insurance.

Claims for dependents will be payable to the member.

6. TRUSTEE DESIGNATION *(Complete only if the beneficiary has not reached legal age)*

I designate the person whose name appears below to act as trustee to receive any amount payable to a beneficiary who is under the legal age or does not have the legal capacity to provide a release. I declare that the release of the said trustee will constitute a valid release for Industrial Alliance with respect to the amount paid.

Trustee's name _____ Social Insurance Number |_|_|_|_|_|_|_|_|_|

Member's signature _____ Date |_|_|_|Y|_|_|M|_|_|D|

MEMBER CONFIRMATION/AUTHORIZATION

I HEREBY APPLY for the benefits which I am or may become eligible, subject to any waiver indicated, under my Employer's/Policyholder's group insurance plan and **CONFIRM** that the information contained in this form is true and complete to the best of my knowledge.

If applying for benefits on my dependents, **I CONFIRM THAT I AM AUTHORIZED** to disclose information concerning them for the purpose of determining their eligibility for coverage.

On behalf of myself and my dependents, **I CONSENT TO THE RELEASE** of the information contained in this form to my Employer/Policyholder and Industrial Alliance, its employees, agents, reinsurers and service providers for the purpose of underwriting, administration, claims processing and the enrolment of me and my dependents in my Employer's/Policyholder's group insurance plan.

If my Social Insurance Number is used as my identification number, **I AUTHORIZE** its use for the administration of my group benefits.

If any contributions are required to be made by me with respect to my group benefits, **I AUTHORIZE** my employer to make any required deductions from my earnings and remit same to Industrial Alliance.

I AGREE that a photocopy of this Confirmation/Authorization shall be as valid as the original.

Member's signature _____ Date |_|_|_|Y|_|_|M|_|_|D|

DISCLOSURE

At Industrial Alliance, the personal information we collect concerning you and your dependents is kept in strict confidence and is only used for the purposes you have authorized.

Your personal file will be kept at Industrial Alliance's offices.

You have the right to request access to your personal information and, if necessary, correct any inaccurate information. In order to do so, send a written request to the following: Industrial Alliance Insurance and Financial Services Inc., Access Officer, 1080 Saint-Louis Road, Sillery, Quebec, G1K 7M3.

Access to your personal information will be limited to Industrial Alliance's employees, agents, reinsurers and service providers in the performance of their jobs, individuals to whom you have granted access, and persons authorized by law.

For the purposes of audits and administrative reporting, Industrial Alliance may release to your Employer/Policyholder statistical financial information without personal identifiers.

Industrial Alliance may establish a list of its insureds to share information within the Industrial Alliance Group. This will help us serve them better and determine whether any products and services that the Industrial Alliance Group offers are suitable so we can offer such products and services to them. However, you are entitled to have your name removed from this list by making a written request to this effect to the Access Officer, as referred to above.

RETURN TO: MDM Insurance Services Inc.
PO Box 966
Guelph, ON N1H 6M6