



ONTARIO HARNESS HORSE ASSOCIATION LIFE/ HEALTH/DENTAL PLAN -- FOR FULLTIME GROOMS REQUESTING 100% PREMIUM ASSISTANCE

NAME OF MEMBER _____
First Middle Last

ADDRESS: _____
Number Street/ R. R. Apt. No.
City Province Postal Code

TELEPHONE: _____ DATE OF BIRTH _____
Residence Business Day Month Year

MEMBERSHIP INFORMATION

OHHA/Standardbred Canada No. _____ ORC License No. _____

OHHA District _____

EMPLOYMENT INFORMATION: Present Employer _____

Length of Employment _____ Monthly Salary \$ _____

TRAINER'S/EMPLOYER'S STATEMENT: I, _____ do hereby certify that
(Print Employer's Name)
_____ is employed by me as a fulltime groom.
(Groom's Name) (Employer's Signature)

PLEASE ENCLOSE A COPY OF YOUR LATEST PAY STUB FOR EMPLOYMENT VERIFICATION

APPLICANT'S STATEMENT: I _____ hereby apply for Grooms' Premium Assistance in the OHHA Life-Health-Dental Insurance Plan. I fully understand that for me to be eligible for this assistance (for single coverage assistance), I must meet at least the following requirements: (A) I do work fulltime as a groom (and I must provide sufficient proof of this, as required by OHHA); (B) I do not own or lease a standardbred horse in whole or part; (C) I am a resident of Ontario; (D) I must be a member of OHHA and in compliance with its bylaws and constitution; (E) I am not trainer of record or driver of a racehorse. I fully understand that if I am also applying for coverage assistance for my household family members (in addition to single coverage for myself), those family members must not own or lease a standardbred horse in whole or in part, or train or drive standardbred horse(s). I further understand that any false statement made on this application will deny myself (and my family members, if I am applying for family coverage) of premium assistance coverage and could result in my OHHA membership being revoked. If my status regarding any of the above changes, I will immediately notify the Ontario Harness Horse Association.

DATE: _____ SIGNATURE: _____

COVERAGE: Single: _____ Family: _____

If you are applying for Family coverage, please complete:

Does he/she own, lease, train or drive a standardbred horse in whole or part?

Table with columns: Spouse's Name, Children's Name(s), Date of Birth (Day, Month, Year), Yes, No

Spouse's Occupation: _____ Spouse's Annual Income: _____

ENROLMENT REQUEST

Please print in ink and sign.

New application Reinstatement

TO BE COMPLETED BY THE PLAN ADMINISTRATOR

Policyholder's name (Employer/organization) OHHA Group policy no. 2 3 3 1 6

Division no. Class no. Location Certificate no.

Employment date: If the period between the employment date and the eligibility date is different from the waiting period in your

Eligibility date: plan, please explain why:

Member's occupation

Salary \$ Weekly Annually Bi-weekly Monthly Hourly - hours worked/week:

COMPLETE THE FOLLOWING BOXES TO REINSTATE A MEMBER:

Date previous employment ended Date rehired on a full-time basis

Additional information

Authorized signature Date

TO BE COMPLETED BY THE MEMBER

1. MEMBER INFORMATION

Last name First name

Date of birth Language English French Sex Male Female

Marital Status Single Divorced/Separated Married/Civil union Common-law - since Other

Address

Street City Province Postal code

2. DEPENDENT'S COVERAGE

Last name	First name	Sex	Date of birth	
Spouse		<input type="checkbox"/> M <input type="checkbox"/> F	<u> </u>	
Child		<input type="checkbox"/> M <input type="checkbox"/> F	<u> </u>	<small>If age 21 or over, specify:</small> Full-time student <input type="checkbox"/> Yes <input type="checkbox"/> No Handicapped <input type="checkbox"/> Yes <input type="checkbox"/> No
Child		<input type="checkbox"/> M <input type="checkbox"/> F	<u> </u>	Full-time student <input type="checkbox"/> Yes <input type="checkbox"/> No Handicapped <input type="checkbox"/> Yes <input type="checkbox"/> No
Child		<input type="checkbox"/> M <input type="checkbox"/> F	<u> </u>	Full-time student <input type="checkbox"/> Yes <input type="checkbox"/> No Handicapped <input type="checkbox"/> Yes <input type="checkbox"/> No

3. COORDINATION AND WAIVER OF BENEFITS (COMPLETE ONLY IF YOU AND/OR YOUR DEPENDENTS ARE COVERED UNDER ANOTHER PLAN)

Check the appropriate boxes

Coverage with the other insurer **Waiving the member's coverage** **Waiving the dependent's coverage**

Health: Individual Family Waived Health Insurance Health Insurance

Dental: Individual Family Waived Dental Care 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 the coverage and you wish to request it at a later date, certain conditions may apply.
Please contact your plan administrator for further details.

**YOU MUST COMPLETE THE MEMBER CONFIRMATION/AUTHORIZATION ON THE REVERSE SIDE.
FAILURE TO DO SO WILL RESULT IN YOUR ENROLMENT NOT BEING PROCESSED.**

4. OPTIONAL BENEFITS (Check with your plan administrator if optional benefits are offered in your group insurance contract.)

	LIFE	AD&D	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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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	
					<input type="checkbox"/> revocable <input type="checkbox"/> irrevocable
					<input type="checkbox"/> revocable <input type="checkbox"/> 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.

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

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 _____

MEMBER CONFIRMATION/AUTHORIZATION

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.

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

Member's signature _____ Date _____

DISCLOSURE

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: OHHA - Kathie Wilkinson
 P.O. Box 429
 Campbellville, ON L0P 1B0