

# CAUS Canadian Benefits

## Value - Value Plus - Business Value Plan

New Individual Enrollment  Reinstatement

Policy # \_\_\_\_\_ Class \_\_\_\_\_ Cert.# \_\_\_\_\_  
TPA Office Use Only

Individual or Employee Name:	Organization Name:	BROKER ID <b>W</b> _____
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### APPLICANT DETAILS

Applicant Last Name: \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initials: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Apt./Unit # Street Address City Province Postal Code

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Email Address: \_\_\_\_\_

Date of Birth: (Day/Month/Year)	Occupation/Job Description:	Start Date is the 1st of the month after the application has been accepted: _____ (Day/Month/Year)
<input type="checkbox"/> Working <input type="checkbox"/> Retired <input type="checkbox"/> Other Income: \$ _____ per _____ (Either: Hourly rate or Month or Year)	Coverage Applying for: <input type="checkbox"/> Value (Guaranteed Issue) <input type="checkbox"/> Value Plus (Medically Underwritten) <input type="checkbox"/> Business Value Plan (Medically Underwritten)	
S.I.N. Number	Do you Smoke: <input type="checkbox"/> Yes <input type="checkbox"/> No	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male

### COVERAGE INFORMATION

Requested Coverage:

Single Coverage (Applicant Only)  Couple (Applicant and Spouse or Applicant and one Dependent)  Family Coverage (Applicant, Spouse, and Dependents)

If applying for Couple or Family coverage:

Does spouse have own coverage?  Yes  No If yes, please complete below.

Are you and your dependent children covered under your spouse's insurance?  Yes  No

Spouse's Employer	Spouse's Insurance Company	Policy Number	Spouse's I.D. Number
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### PREVIOUS INSURANCE CARRIER (If applicable)

For Value Plus and Business Plan applicants: if you are converting from a previous group plan within 60 days of its termination, pre-existing conditions will be covered subject to policy wordings and exclusions. I am converting from another group plan which terminated on \_\_\_\_\_ (Day/Month/Year)

My previous insurance carrier was \_\_\_\_\_ Plan # \_\_\_\_\_

### DEPENDENT INFORMATION (include a list of additional dependents if necessary)

	Last Name	First Name	Middle Initial	Gender M / F	Date of Birth Day/Month/Year
Spouse					
1st Child					
2nd Child					
3rd Child					

### BENEFICIARY DESIGNATION

I hereby name the following revocable (irrevocable in Quebec) beneficiary(ies) of any Life Insurance benefits payable under this plan. If not specified, the Beneficiary will be the Estate. If any Beneficiary is a minor a Trustee should be named on their behalf.

\_\_\_\_\_ Last Name First Name/Middle Initial Relationship to Employee

This enrollment form and medical form should be mailed or given to your broker

