



# MEMBERSHIP REQUEST GROUP INSURANCE

CERTIFICATE  
(FOR INSURER ONLY)

EMPLOYER'S NAME		GROUP	DIVISION	EMPLOYEE ID.	S.I.N	EMPLOYEE'S E-MAIL (REQUIRED)	
EMPLOYEE'S LAST NAME		FIRST NAME			LANGUAGE <input type="checkbox"/> FR. <input type="checkbox"/> EN.	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH Y   M   D
EMPLOYEE'S ADDRESS N° STREET APT CITY PROVINCE POSTAL CODE							
DATE OF EMPLOYMENT Y   M   D	OCCUPATION	CLASS	SALARY \$	# HOURS / WEEK	<input type="checkbox"/> ANNUAL <input type="checkbox"/> MONTHLY	<input type="checkbox"/> WEEKLY <input type="checkbox"/> HOURLY RATE	PHONE NUMBER
CIVIL STATUS : <input type="checkbox"/> SINGLE <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> CIVIL UNION						DATE OF COHABITATION'S BEGINNING : Y   M   D	

### COVERAGE (IF YOU HAVE CHOSEN A PROTECTION FOR YOUR DEPENDANTS, PLEASE FILL IN THE DEPENDANTS SECTION)

DESIRED PROTECTION : <input type="checkbox"/> INDIVIDUAL WITH DEPENDANTS LIFE <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> COUPLE <input type="checkbox"/> FAMILY <input type="checkbox"/> SINGLE PARENT	
IS YOUR SPOUSE COVERED UNDER ANOTHER INSURANCE PLAN : HEALTH CARE : <input type="checkbox"/> YES <input type="checkbox"/> NO DENTAL CARE : <input type="checkbox"/> YES <input type="checkbox"/> NO	SPOUSE'S COVERAGE : <input type="checkbox"/> SINGLE <input type="checkbox"/> COUPLE <input type="checkbox"/> FAMILY <input type="checkbox"/> SINGLE PARENT <input type="checkbox"/> SINGLE <input type="checkbox"/> COUPLE <input type="checkbox"/> FAMILY <input type="checkbox"/> SINGLE PARENT

### EXEMPTION REQUEST :

<input type="checkbox"/> FOR MYSELF AND MY DEPENDANTS :	<input type="checkbox"/> HEALTH CARE AND DRUG INSURANCE BENEFIT	<input type="checkbox"/> DENTAL CARE BENEFIT
<input type="checkbox"/> FOR MY DEPENDANTS ONLY :	<input type="checkbox"/> HEALTH CARE AND DRUG INSURANCE BENEFIT	<input type="checkbox"/> DENTAL CARE BENEFIT
SPOUSE INSURER NAME :	SPOUSE PLAN NUMBER :	SPOUSE CERTIFICATE NUMBER :

### DEPENDANTS

LAST NAME	FIRST NAME	RELATIONSHIP	SEX	DATE OF BIRTH	* PROOF OF FULL-TIME STUDY REQUIRED ** PROOF REQUIRED	FULL-TIME STUDENT (AGE 21 OR MORE)*	DISABLED DEPENDANT **
		<input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD	<input type="checkbox"/> M <input type="checkbox"/> F	Y   M   D		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
		<input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD	<input type="checkbox"/> M <input type="checkbox"/> F	Y   M   D		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
		<input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD	<input type="checkbox"/> M <input type="checkbox"/> F	Y   M   D		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
		<input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD	<input type="checkbox"/> M <input type="checkbox"/> F	Y   M   D		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

### BENEFICIARY IN CASE OF DEATH

NOTE: IN QUEBEC, UNLESS OTHERWISE STIPULATED, THE DESIGNATION OF A LEGAL SPOUSE IS IRREVOCABLE. ANY OTHER DESIGNATION IS REVOCABLE.

LAST NAME :	FIRST NAME :	RELATIONSHIP :	%	<input type="checkbox"/> REVOCABLE <input type="checkbox"/> IRREVOCABLE
LAST NAME :	FIRST NAME :	RELATIONSHIP :	%	<input type="checkbox"/> REVOCABLE <input type="checkbox"/> IRREVOCABLE

### AUTHORIZATION

I AUTHORIZE ANY HEALTH PROFESSIONAL AND ANY PUBLIC OR PRIVATE INSTITUTION OF HEALTH AND SOCIAL SERVICES, ANY INSURANCE COMPANY, THE MEDICAL INFORMATION BUREAU (MIB), PERSONAL INFORMATION AGENTS OR INVESTIGATION AND SECURITY AGENCIES, MY EMPLOYER OR FORMER EMPLOYER AND ANY PUBLIC BODY HOLDING INFORMATION TO SEND SUCH INFORMATION TO THE INSURER, THE REINSURERS AND THEIR SERVICES' PROVIDERS IF NECESSARY FOR ANY RISK ASSESSMENTS OR CLAIM STUDIES. I ALSO AUTHORIZE MY INSURER OR HIS REINSURERS TO EXCHANGE WITH OTHER INSURERS OR PEOPLE THAT I HAVE GIVEN AS A REFERENCE, THE PERSONAL INFORMATION CONTAINED IN THIS APPLICATION AND TO INVESTIGATE THEM WHEN ASSESSING THE RISKS OR WHEN STUDYING CLAIMS. I ALSO AUTHORIZE UL MUTUAL (THE UNION LIFE, MUTUAL ASSURANCE COMPANY) TO MAKE A BRIEF REPORT OF MY PERSONAL HEALTH INFORMATION TO THE BUREAU OF MEDICAL INFORMATION (MIB). I AGREE TO COOPERATE AND SIGN ANY SPECIFIC AUTHORIZATION DOCUMENT THAT MAY BE REQUIRED OR NECESSARY FOR THE INSURER TO OBTAIN INFORMATION TO EVALUATE PROPERLY THE SITUATION. A COPY OF THIS AUTHORIZATION OR THIS CONSENT HAS THE SAME VALUE AS THE ORIGINAL.

IN THE EVENT OF MY DEATH, I EXPRESSLY AUTHORIZE THE BENEFICIARY, HEIR OR OFFICIAL LIQUIDATOR OF MY SUCCESSION TO PROVIDE TO THE INSURER, HIS REINSURERS AND THEIR SERVICES' PROVIDERS UPON REQUEST, ANY INFORMATION OR NECESSARY AUTHORIZATIONS REQUIRED FOR THE STUDY OF THE DEATH CLAIM OR TO OBTAIN ANY SUPPORTING DOCUMENTATION.

I REQUEST TO JOIN MY EMPLOYER'S GROUP INSURANCE CONTRACT ISSUED BY UL MUTUAL AND I ACKNOWLEDGE HAVING READ THE NOTICE ON THE ESTABLISHMENT OF A PERSONAL FILE INDICATED AT THE BOTTOM OF THIS PAGE.

I AUTHORIZE MY EMPLOYER TO DEDUCT FROM MY SALARY THE REQUIRED PREMIUM IN REFERENCE TO THE PROTECTIONS I HAVE SELECTED AND TO UPDATE THE NECESSARY INFORMATION FOR THE ADMINISTRATION OF THE INSURER'S FILE. ALL SUBMITTED INFORMATION CONSTITUTES AN AFFIRMATIVE GUARANTEE FROM MY PART.

DATE \_\_\_\_\_ EMPLOYEE'S SIGNATURE **X** \_\_\_\_\_

### TO BE COMPLETED BY THE POLICYHOLDER ADMINISTRATOR

EMPLOYMENT STATUS <input type="checkbox"/> PERMANENT FULL TIME <input type="checkbox"/> PERMANENT PART-TIME <input type="checkbox"/> TEMPORARY FULL TIME <input type="checkbox"/> TEMPORARY PART-TIME	ELIGIBILITY DATE Y   M   D	REMARKS
POLICY ADMINISTRATOR NAME :	PHONE NUMBER	

I CERTIFY THAT THE ABOVE INFORMATION IS ACCURATE AND COMPLETE

DATE \_\_\_\_\_ SIGNATURE OF THE POLICY ADMINISTRATOR **X** \_\_\_\_\_

### NOTICE RELATING TO THE CONSTITUTION OF A FILE

ALL PERSONAL INFORMATION CONTAINED IN THIS DOCUMENT WILL BE KEPT IN A GROUP INSURANCE FILE WITH UL MUTUAL AND IN YOUR PERSONAL HEALTH FILE WITH SERVICES PROVIDERS OF THE INSURER. THE INFORMATION WILL BE USED TO EVALUATE THIS REQUEST FOR GROUP INSURANCE AND TO PROCESS ANY CLAIM. ONLY EMPLOYEES, AUTHORIZED AGENTS AND SERVICES PROVIDERS DULY AUTHORIZED BY UL MUTUAL WILL HAVE ACCESS TO THIS INFORMATION IN THE COURSE OF BUSINESS TRANSACTIONS. YOUR GROUP INSURANCE FILE WILL BE IN CUSTODY OF UL MUTUAL AT UL MUTUAL'S OFFICE. WITH A WRITTEN REQUEST AND A 30 DAYS NOTICE, YOU HAVE THE RIGHT TO REVIEW THE PERSONAL INFORMATION CONTAINED IN YOUR FILE AND IF NECESSARY, A RECTIFICATION REQUEST CAN BE MADE IN ACCORDANCE WITH THE ACT RESPECTING THE PROTECTION OF PERSONAL INFORMATION IN THE PRIVATE SECTOR. PLEASE ADDRESS YOUR REQUEST TO UL MUTUAL, TO THE ATTENTION OF THE PRIVACY OFFICER, 142 HERIOT STREET, BOX 696, DRUMMONDVILLE, QC J2B 6W9