UL MUTUAL

SUPPLEMENTARY INFORMATION
DECLARATION OF DEPENDANTS
DESIGNATION OF BENEFICIARY

GROUP INSURANCE

MEMBER INFORMATION

NAME AND SURNAME OF MEMBER	NAME OF EMPLOYER	GROUP	CERTIFICATE (If known)

ADDRESS OF MEMBER	NO.	STREET	APT.	CITY	PROVINCE	POSTAL CODE

REGISTRATION TO DIRECT DEPOSIT Please attach a specimen	TRANSIT 5 DIGITS	BRANCH 3 DIGITS	FOLIO 7 DIGITS	EMAIL ADDRESS	PHONE NUMBER

INFORMATION ON THE SPOUSE AND DEPENDENT CHILDREN

☐ CIVIL STATUS SINGLE WITHOUT A SPOUSE OR A CHILD

RELATIONSHIP	NAME	SURNAME	DATE OF BIRTH (YYYY/ MM /DD)	SEX	CHECK IF APPLICABLE EVIDENCE REQUIRED	COVERED BY ANOTHER GROUP INSURANCE?
☐ SPOUSE				☐ F ☐ M		☐ YES ☐ NO
☐ CHILD				☐ F ☐ M	☐ STUDENT AGED +21 ☐ DISABLED	☐ YES ☐ NO
☐ CHILD				☐ F ☐ M	☐ STUDENT AGED +21 ☐ DISABLED	☐ YES ☐ NO
☐ CHILD				☐ F ☐ M	☐ STUDENT AGED +21 ☐ DISABLED	☐ YES ☐ NO
☐ CHILD				☐ F ☐ M	☐ STUDENT AGED +21 ☐ DISABLED	☐ YES ☐ NO
☐ CHILD				☐ F ☐ M	☐ STUDENT AGED +21 ☐ DISABLED	☐ YES ☐ NO

* CHILDREN AGED BETWEEN 21 AND 26 YEARS OLD MUST PROVIDE AN EVIDENCE OF FULL-TIME STUDIES TO REMAIN INSURED AS A DEPENDANT UNTIL THEIR 26TH ANNIVERSARY. ONLY COURSE SCHEDULES ISSUED LESS THAN ONE MONTH BEFORE THE BEGINNING OF A SEMESTER ARE ACCEPTED.

COORDINATION OF BENEFITS

PLEASE COMPLETE THIS SECTION IF YOU OR ONE OF YOUR DEPENDANTS IS COVERED BY ANOTHER GROUP INSURANCE.

NAME OF INSURER OF THE OTHER CONTRACT AND PERIOD OF INSURANCE	TYPE OF COVERAGE	BENEFITS HELD
☐ UL MUTUAL: ____CERTIFICATE____ ☐ OTHER: ______________ FROM: ____YYYY / MM /DD____ TO: ____YYYY/ MM /DD____	☐ INDIVIDUAL ☐ COUPLE ☐ SINGLE-PARENT ☐ FAMILY	☐ DRUGS ☐ DENTAL CARE ☐ HEALTH ☐ VISUAL CARE ☐ TRAVEL

DESIGNATION OF BENEFICIARY(IES)

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

PROPORTION	SURNAME	NAME	RELATIONSHIP	DESIGNATION
_____ %				☐ REVOCABLE ☐ IRREVOCABLE
_____ %				☐ REVOCABLE ☐ IRREVOCABLE
_____ %				☐ REVOCABLE ☐ IRREVOCABLE
_____ %				☐ REVOCABLE ☐ IRREVOCABLE

X ______________________ SIGNATURE OF MEMBER

X ______________________ SIGNATURE OF GROUP INSURANCE ADMINISTRATOR

X ____YYYY/ MM /DD____ DATE

RETURN TO:

UL MUTUAL

142 HERIOT STREET, P.O. BOX 696, DRUMMONDVILLE, QUEBEC J2B 6W9

PHONE: 819-478-1315 EXTENSION 2076 - TOLL-FREE: 1-800-567-0988 - FAX: 819-474-1990

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