Comité paritaire des boueurs de la région de Montréal

Policy number: 180763 | Canada Life

! Space reserved for the Comité paritaire des boueurs

Division	Benefit class	Coverage start date	Insurable earnings	Social insurance number
		Day Month Year		

Employer name: _____

Insured information

Last name: _____

First name: _____

Gender: ☐ Female ☐ Male

Date of birth: _____ _____ _____
Day Month Year

Language: ☐ English ☐ French

Address: _____

City: _____

Province: _____

Postal code: _____

Telephone: _____

Email: _____

Type of work

☐ Roll-off ☐ Side loader driver

☐ Other vehicle ☐ Helper

Not governed by the decree

☐ Office

☐ Other work (specify): _____

Civil status

☐ Single ☐ Married ☐ Common-law

Coverage requested

☐ Family ☐ Single parent ☐ Individual*

*By requesting individual coverage, I attest that any dependants of mine eligible for group insurance coverage are covered by another private medical insurance plan.

Dependant information

Family coverage:
Fill out below for spouse and children, if applicable

Single-parent coverage:
Fill out below for children only

Individual coverage:
Do not fill out this section

Relationship	Last name	First name	Gender	Date ot birth			Status S = Student D = Disabled
				Day	Month	Year	
Spouse			☐ F ☐ M				☐ S ☐ D
Child			☐ F ☐ M				☐ S ☐ D
Child			☐ F ☐ M				☐ S ☐ D
Child			☐ F ☐ M				☐ S ☐ D
Child			☐ F ☐ M				☐ S ☐ D

Beneficiary designation(s)

☐ Revocable ☐ Irrevocable*

Last name	First name	Relationship	% share

*In Quebec, a spouse (through marriage or civil union) named as beneficiary is irrevocable, unless you check the "Revocable" box.

If you would like to name more than four beneficiaries, please contact the Comité paritaire for a more comprehensive form.

Consent

Personal information	I am aware that the personal information requested in this application form is necessary for membership in the group insurance plan of the Comité paritaire des Boueurs de la région de Montréal. I consent for this information to be collected and shared with my employer, the policy holder, the plan administrator and the insurer, for these purposes exclusively, so long as my coverage remains in force. Once my coverage has lapsed, this information will be deleted.
Beneficiary	In the event of my death, I expressly authorize my beneficiary or beneficiaries, heirs or the liquidator of my succession to give the insurer all information, evidence and authorizations deemed necessary to review the request for life insurance benefits. If a legal beneficiary has not been designated and the beneficiary fields have been left empty, the benefits will be paid to the succession of the deceased member.
Payroll deductions	I authorize my employer to deduct the necessary contributions from my earnings.
Attestation	I declare that I have reviewed all of the information in this form and that it is true and complete. A photocopy of this document has the same force and effect as the original. I hereby certify that, to the best of my knowledge, the provided information is complete, true and accurate. **Insured signature:** _____ **Date :** _____

Once completed and signed, please email the form to the Comité paritaire: eramos@boueurs.com