Adminplex Resource Services Inc.

30 Kelfield Street, Toronto, ON M9W 5A2

1.800.565.2467
Fax: 289.304.9052

Life Insurance Enrollment Form

Purpose of Life Insurance Enrollment Form is to provide the required information to enroll an individual in Group Life Insurance coverage.

Name of Policyholder	Policy Number	Division	Class	Department Number

Employee's Name (Last Name, First Name)	Certificate/Employee ID Number

Date of Birth ____ (mmm/dd/yyyy)	Gender: ☐ Male ☐ Female	Province of Residence:	Language: ☐ English ☐ French	Social Insurance Number

Salary	Salary Basis ☐ Hourly ☐ Annual ☐ Bi-weekly	# of hours worked	Occupation

Home Address

Street ________ City ________ Postal Code ________

Beneficiary Designation

Unless otherwise designated, the beneficiary appointment is 'Revocable'. If no beneficiary is designated, the beneficiary will be the estate of the deceased. Province of Quebec Residents, note, the appointment of a spouse as beneficiary is considered 'irrevocable' unless the word 'revocable' is actually written after the spouse's name.

Last Name and Full First Name	Percentage	Relationship

For employees with minor beneficiaries:

I appoint (full name)____________________________, on ___________________, 20______ as Trustee to receive any amount payable to a minor beneficiary under this policy. The Trustee shall discharge the Insurer for the amount paid. I authorize the Trustee to spend all or part of the amount, or interest earned on it, for the support or education of the minor.

Signature ____________________ Date ____________________

Declaration

I authorize Adminplex Resource Services Inc. and affiliated companies, strictly for the purposes of providing group insurance to;
- collect from me and my employer only information deemed necessary to provide group insurance.
- communicate the said information only to organizations deemed necessary to provide and process my group insurance.

I am applying for insurance coverage in accordance with the provisions and conditions of the Group Insurance Contract issued at the Policyholder's request. I authorize the policyholder to deduct from my earnings the required contribution for the insurance to which I am or may be entitled. I authorize the use of my social insurance number for group insurance identification purposes and as required by law, for income tax reporting.

Signature Of Participant ____________________ Date ____________________

Date of Employment: ____________________ (mmm/dd/yyyy)

Effective Date of Coverage: ____________________ (mmm/dd/yyyy)