

Enrolment Form for Extended Health Care Insurance for Retirees



Reference number 50134

In this Enrolment Form for Extended Health Care Insurance for Retirees *you* and *your* refer to the person applying for insurance. *We, us, our* and *the Company* refer to Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies.

Please PRINT clearly.

Complete all sections if applying for coverage during the 60-day open enrolment period (from the date of your retirement or the date your group benefits terminate). If you have missed the 60-day open enrolment period, please contact your local Chapter Representative for an Enrolment/Application Form, proof of good health will be required.

1 General information

Eligibility to apply:

All retired employees and/or their spouse who meet the eligibility definition for benefits at the time of retirement.

Information about you

| | | | |
|--|------------|--|-----------------------|
| Name (first, middle initial, last) | | <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of birth (d/m/y) |
| Former/maiden name (if applicable) | | Language <input type="checkbox"/> English <input type="checkbox"/> French | |
| Residence address (street number and name, apartment or suite) | | | |
| City | Province | Postal code | |
| Telephone (home) () | Fax () | | |
| E-mail address | | Are you a resident of Canada and covered under the provincial health plan in your province of residence? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Date of retirement (d/m/y) | | Name of most recent employer Police Pensioners Association of Ontario | |

Please complete if applying for Spousal insurance.

Information about your spouse

| | | | |
|------------------------------------|--|--|-----------------------|
| Name (first, middle initial, last) | | <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of birth (d/m/y) |
| Former/maiden name (if applicable) | | Language <input type="checkbox"/> English <input type="checkbox"/> French | |
| E-mail address | | Are you a resident of Canada and covered under the provincial health plan in your province of residence? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Date of retirement (d/m/y) | | | |

Please complete if applying for Dependent child(ren) insurance.

Information about your dependent child(ren)

| | | | |
|------------------------------------|--|-----------------------|---|
| Name (first, middle initial, last) | <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of birth (d/m/y) | Student <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Name (first, middle initial, last) | <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of birth (d/m/y) | Student <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Name (first, middle initial, last) | <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of birth (d/m/y) | Student <input type="checkbox"/> Yes <input type="checkbox"/> No |

If you need more space, please complete on separate sheet of paper, and sign and date it.

2 Plan applied for at this time

Standard Plan Enhanced Plan

3 Coverage applied for at this time

Retiree only Retiree + 1 Retiree + 2 or more

4 Insurance information

Did you or your spouse have Extended Health Care or Dental coverage immediately prior to retirement?

You

Yes If yes, please provide details below. No

Your spouse

Yes If yes, please provide details below. No

Insuring company

| | |
|--|--------------------------------------|
| | <input type="checkbox"/> You |
| | <input type="checkbox"/> Your spouse |
| | <input type="checkbox"/> You |
| | <input type="checkbox"/> Your spouse |

5 Premium payments

Please complete this section if you'd like to have us collect your premium payment directly from your bank account.

a) Monthly pre-authorized cheque (PAC)

| | | |
|---|---------------|-----------|
| Name of account holder (first, middle initial, last) | | |
| Name and address of your financial institution (street number and name) | | |
| Transit # | Institution # | Account # |

Please attach a personal blank cheque, marked VOID across the front, to this application form.

Terms and conditions

In connection with your required premium under this benefit plan, you agree that:

- your bank or financial institution is authorized to treat any withdrawal by Sun Life Assurance Company of Canada as though it was made by you personally
- you or Sun Life Assurance Company of Canada may cancel this pre-authorized payment agreement at any time by giving notice in writing
- the agreement is cancelled automatically if Sun Life Assurance Company of Canada is unable to make a withdrawal from your account

| |
|----------------------------------|
| Signature of account holder X |
|----------------------------------|

Please complete this section if you'd like to have your insurance premium charged to your VISA® or MasterCard®.

b) Monthly credit card payment

Type of card MasterCard® VISA®

| | | |
|---------------------------------------|-------------|-------------------|
| Name of cardholder as appears on card | Card number | Expiry date (m/y) |
|---------------------------------------|-------------|-------------------|

Terms and conditions

In connection with your required premium under this benefit plan, you authorize us:

- to charge your credit card for the insurance premium owing
- to cancel this authorization 10 days after you have provided written notice to us
- to automatically cancel this agreement if we are unable to charge your credit card

| |
|------------------------------|
| Signature of cardholder X |
|------------------------------|

Send no money with this application. You will be notified with a premium statement.

6 Declaration and authorization

I declare that my answers in this Enrolment Form are true and complete and I understand that concealment, misrepresentation and false declaration concerning this Enrolment Form will cause the insurance to be void.

I authorize Sun Life Assurance Company of Canada, and its agents and service providers to use and exchange information needed for underwriting, administration and adjudicating claims under this insurance coverage with any person or organization who has relevant information about me including institutions, investigative agencies, insurers, and reinsurers.

A photocopy or electronic version of this authorization is as valid as the original.

| | |
|---------------------------------|--|
| Your signature X | Your spouse's signature (if applying) X |
| Location signed (city/province) | Date (d/m/y) |

Please return completed Enrolment Form to:

**Sun Life Assurance Company of Canada
Association & Affinity Business
P.O. Box 365 Stn Waterloo
Waterloo, ON N2J 4A4**