GROUPE FINACTION
Assurance collective • Vie • Invalidité • Retraite

GROUP INSURANCE APPLICATION FORM

RESERVED FOR ADMIN/INSURER : Policy N° : ________________ Division N° : ______ Identification N° : __________________

SECTION 1 – GENERAL INFORMATION

Employer name (name of branch/division): ____ Branch/division N° : _______

Last name : ____ First name : ____

Gender : M F Language : French English Date of birth (DD/MM/YYYY) :_____________________ Smoking : Non-smoking Smoking

Address : ____ Apartment : _______

City : ____ Province : ________ (of residence) Postal code : ______________ Province : ________ (of employment)

Home phone N° : ______-______-_______ Email : ____

Civil status : Single Separated Married Common law **If common law indicate start date of cohabitation (MM/YYYY) :* ___________

SECTION 2 – TO BE COMPLETED BY EMPLOYER

Job Title : _____________________________________ Division : ________________ Class : ________________________________

Date hired : ________________ (DD/MM/YYYY) Coverage eligibility date : ________________ (DD/MM/YYYY) Work hours/Week : ________

Annual salary : _________________$ **Signature of the employer** ____

SECTION 3 – TYPE OF COVERAGE (SECTION OBLIGATOIRE)

Health insurance :
- Individual plan
- Family plan
- Single parent
- Exemption – covered with spouse ***Proof of insurance required for exemption*** (send proof with current form)

Dental care :
- Individual plan
- Family plan
- Single parent
- Exemption – covered with spouse ***Proof of insurance required for exemption*** (send proof with current form)

**Insurance proofs accepted* : One amongst the following : copy of the insurance card on which your name appears, screen shot from your spouse's insurer's portal where we can see your name as an insured person, insurance confirmation letter from your spouse's insurer (or employer) where your name is listed as an insured person*

Optional life insurance : I would like to purchase an additional life insurance in addition to the basic plan. Please contact me.

SECTION 4 – DEPENDENT'S INFORMATION

	Last name	First name	Gender (M/F)	Date of birth (DD/MM/YYYY)	Full time student
Spouse					
Child 1					Yes
Child 2					Yes
Child 3					Yes
Child 4					Yes

SECTION 5 –DESIGNATION OF BENEFICIARIES FOR LIFE INSURANCE

Last name : ______________________ First name : ____________________ _____% Relationship: ________________ Revocable Irrevocable

Last Name: ______________________ First name : ____________________ _____% Relationship : ________________ Revocable Irrevocable

Last name : ______________________ First name : ____________________ _____% Relationship : ________________ Revocable Irrevocable

I want my life insurance to be distributed equally between my beneficiaries

Except during an irrevocable designation, you can change your beneficiary at any time without consent. IN QUEBEC : THE DESIGNATION OF YOUR SPOUSE AS BENEFICIARY IS IRREVOCABLE UNLESS OTHERWISE NOTED.

Send the original copy to :
72 rue De Martigny Ouest, Saint-Jérôme, QC, J7Y 2E9
and send us an email copy at collectif@groupefinaction.com (for an accelerated processing)

SECTION 6 - SIGNATURE OF THE PARTICIPANT, AUTHORIZATION AND DÉCLARATION

I DECLARE THAT THE INFORMATION PROVIDED IS ACCURATE. I AUTHORIZE MY EMPLOYER TO DEDUCT FROM MY PAY THE PREMIUM REQUIRED THEREFORE THE PROTECTION THAT I HAVE CHOSEN. I HEREBY AUTHORIZE THE INSURER AND ITS SERVICE PROVIDERS TO COLLECT AND EXCHANGE MEDICAL INFORMATION ABOUT MYSELF, MY SPOUSE AND/OR MY CHILDREN WITH HEALTH CARE PROFESSIONALS, MEDICAL AND SOCIAL SERVICE INSTITUTIONS AND GOVERNMENT AGENCIES (SUBJECT TO APPLICABLE LAW). I FURTHER AUTHORIZE THE LATTER PARTIES TO TRANSMIT SUCH INFORMATION TO THE INSURER AND ITS SERVICE PROVIDERS WITH A VIEW TO ENABLE THE INSURER AND ITS SERVICE PROVIDERS TO REVIEW ANY CLAIMS MADE UNDER THE GROUP INSURANCE POLICY AND TO MAINTAIN INDIVIDUAL HEALTH RECORDS EXCLUSIVELY FOR PURPOSES OF ADMINISTRATION OF THE GROUP PLAN. IN THE EVENT OF MY DEATH, I EXPRESSLY AUTHORIZE MY BENEFICIARY, HEIR OR EXECUTOR TO PROVIDE THE INSURER AND ITS SERVICE PROVIDERS ALL INFORMATION AND/OR AUTHORIZATION REQUIRED TO ENABLE THE REVIEW OF CLAIMS AND THE COLLECTION OF SUPPORTING DOCUMENTATION.

______________________________	______________________________
Signature of the participant (mandatory)	Date (DD/MM/YYYY)

DIRECT DEPOSIT – PLEASE JOIN A VOID CHECK FOR AN ACCELERATED REIMBURSEMENT

I want to benefit from the free direct deposit service for my insurance claims Yes No

PASTE YOUR VOID CHECK HERE

VERIFICATION CHECKLIST BEFORE SENDING YOUR APPLICATION

- ❑ Be sure that all sections are completed, all requested information is provided and that the signature of the participant appears at the section 6 and the employer's signature at section 2.
- ❑ At section 2, please ensure the salary is specified (if you provide an hourly rate, please include the weekly hours)
- ❑ If you're covered with your spouse for medical and/or dental care,
  - Join your mandatory insurance proof
  - Make sure you have filled the «dependants information» (section 4)
- ❑ If you wish to benefit from the direct deposit, make sure to attach a void check
- ❑ Optional: For an accelerated treatment, send us a copy by email at collectif@groupefinaction.com
- ❑ **Mandatory** : send the original form to :

GROUPE FINACTION – GROUP BENEFITS
72 RUE DE MARTIGNY OUEST
SAINT-JEROME, QC, J7Y 2E9