SERVICE COLLECTIF TOTAL Inc.

3078 Dagenais Blvd. West, Laval, Quebec H7P 1T6
Tel.: (450) 625-7000 Toll free: 1 (888) 625-7001 Fax: (450) 625-8333
www.sctotal.com

Enrolment Request

(Fill out in ink and in block letters, sign and forward the **original** to us keeping a copy for your files)

❒ Enrolment
❒ Modification (effective date) _____

Reserved for Service Collectif Total

Reçu : _____

Entré : _____ par _____

Telus: _____ par _____

Num. : _____ par _____

PARTICIPANT

Policyholder (Employer)			**Policy No.**	
Identification No. (attributed by SCT)	**Employee No.** (attributed by SCT)	**Current Position**	Division or Acct No	**Class**
Name		**Given Name**	**Date of Birth** (YYYY-MM-DD)	
Address No. Street Apt.		**City**	**Province**	**Postal Code**

Marital Status
❒ Single ❒ Married / Civil Union
❒ Separated/divorced
❒ Common-law Cohabitates since _____
❒ Widowed

Date of employment (YYYY-MM-DD)

Date of eligibility (YYYY-MM-DD)

Employment Status
❒ Full-time
❒ Part-time ----------> Number hours / week ____
❒ Permanent ----------> since _____ (YYYY-MM-DD)
❒ Seasonal ❒ Contractual ❒ Self-employed

Correspondence
❒ English
❒ French

Gender
❒ Female
❒ Male

Annual Salary

Reason for Modification

CHOICE OF COVERAGE

Supplemental Health Insurance
❒ Individual Coverage
❒ Family Coverage
❒ Single-parent Coverage *
❒ Couple Coverage *
❒ Exempt ----------→

Dental Care Insurance
❒ Individual Coverage
❒ Family Coverage
❒ Single-parent Coverage *
❒ Couple Coverage *
❒ Exempt ----------→

Participant's Optional Life Insurance * ❒ No ❒ Yes

_____ units of $10,000 (maximum $100,000)

Please indicate the desired protection and complete the following declaration --------→

* if offered within your plan

❒ **EXEMPTION REQUEST**

If you or your dependants are covered by another group insurance plan, you can waive the following benefits which are already covered by the other plan.

Exempt ❒ the **participant** ❒ the **dependants** for ❒ Supplemental Health Insurance ❒ Dental Care Insurance

_____ Name of insured person

_____ Employer

_____ Policy No. _____ Certificate No.

_____ Name of Insurance Company

❒ **TERMINATION OF EXEMPTION**

Reason _____

_____ Participant's Signature

Date _____

Declaration: In the past 12 months, have you used tobacco in any form? ❒ No ❒ Yes

The Optional Life Insurance will only take effect on the date the evidence is accepted by the Insurer unless the policy provisions allow participants to obtain a benefit without evidence of insurability. Note – A false declaration with respect to tobacco use will lead to cancellation of this optional benefit.

DEPENDANTS' COVERAGE

Identify your dependants only if you choose Family (Single-Parent or Couple) coverage in Supplemental Health Insurance and Dental Care Insurance.

Relation	Last Name	Given Name	Sex	Date of Birth			Status of children If age 21 or older, specify:
Spouse			❒ F ❒ M	Year	Mth	Day	
Child			❒ F ❒ M	Year	Mth	Day	❒ Full-time Student ❒ Handicapped
Child			❒ F ❒ M	Year	Mth	Day	❒ Full-time Student ❒ Handicapped
Child			❒ F ❒ M	Year	Mth	Day	❒ Full-time Student ❒ Handicapped

BENEFICIARY DESIGNATION (for Participant's Life Insurance)

Last Name(s), Given Name(s)	Relation(s) to the Insured	*
		❒ Revocable ❒ Irrevocable

*** In Quebec, if no designation is made, the designation of the legal spouse is irrevocable and any other choice is revocable.**
Designating an irrevocable beneficiary can have important consequences; among others, if you wish to change your beneficiary at a later date, you will need his / her consent (or that of his / her legal guardian if a minor).

AUTORIZATION AND SIGNATURE

AUTORIZATION – I hereby authorize my employer to deduct the required premiums from my salary, the Insurer and the Administrator to use my social insurance number for identification and administration purposes. Furthermore, I authorize any physician, any other professional and intervening party in the field of health and rehabilitation, as well as any public or private health or social services institution, any insurance company, as well as any reinsurer, any public or private organization, any information agency that will have received such a mandate, any market intermediary, any employer or ex-employer, the policyholder as well as any person holding personal files or information, especially medical records pertaining to me, as the case may be, to provide the Insurer, or to its representatives, any information that it holds, required for the processing of my file.

I also authorize the Insurer to transmit such information to the aforementioned persons when necessary, within the scope of its activities and the processing of my file.

In the event of death, I specifically authorize the policyholder, the employer, the beneficiary, the heir or the executor of my succession to provide the Insurer or its representatives when necessary, with all information or authorizations permitting the processing of my file.

This consent is valid for the purpose of this contract, its amendment, extension or renewal. A photocopy of this consent has the same value as the original.

_____ Participant's signature

Tel No. ( )_____

Date _____

I declare that to my knowledge, the above information is true and that this participant is: Covered by the CSST (Workers' Compensation): ❒ Yes ❒ No by Employment Insurance: ❒ Yes ❒ No

_____ Signature of Employer's representative (required) and Name in Capital Letters

Tel No. ( )_____

Date _____