

Employee Enrollment

TotalGuard

This form is to be completed by the employee.

Employer Information

Firm Name		Street Address	
City	Province	Postal Code	Telephone Number

Employee Information

Employee Name (first, initial, last)				Birth Date (yy/mm/dd)		Gender M F U		
Address				City		Province		Postal Code
Telephone Number		Number of Hours Worked Per Week				Number of Months You Will be Working Per Year		
Gross Earnings \$		Annually	Monthly	Bi-Weekly	Hourly	Date of Full Time Hire (yy/mm/dd) (20 hours or more per week)		
Insurance Class		Is this Application Due to Reinstatement? Yes No				Date of Rehire (yy/mm/dd)		
Occupation		Are you: Legally Married Common-Law Spouse				If Common-Law Spouse, Cohabitation Date (yy/mm/dd)		
Is Employee Covered Under the Provincial Health Plan? Yes No				Are All Dependents Covered Under the Provincial Health Plan? Yes No				

Coverage Information

I hereby apply for insurance under Western Financial Group, subject to all terms, conditions and provisions of the policy, and authorize the necessary premium deductions from my earnings.

Coverage Designation (select only one)	Single	Family	Partial*
*You may choose Partial, only if you are covered under your spouses plan.			
Does your Spouse have coverage elsewhere?	Health: Yes No	Dental: Yes No	
	If Yes: Single Family	If Yes: Single Family	
If Yes, Please indicate Policy Number	Insurance Company		

You may opt out of benefits for yourself and your dependents only if you are covered for similar benefits under your spouse’s plan. You may apply at a later date for benefits you have refused. Certain conditions may apply.

To be eligible for Extended Health Care benefits, you and your dependents must be registered and covered through your applicable provincial health plan.

**Please retain a copy of the completed form for your records.*

Family Information - Please complete this section with spouse & dependent children regardless of coverage selected.

Name of Dependent(s)	Birth Date (yy/mm/dd)	Gender	Relationship to Employee	Birth Date (yy/mm/dd)	Full Time Student*
		M F U		Yes No	Yes No
		M F U		Yes No	Yes No
		M F U		Yes No	Yes No
		M F U		Yes No	Yes No
		M F U		Yes No	Yes No

*Please submit a Western Financial Group Over-age Dependent Coverage form for any child over age 21 who is a FULL-TIME STUDENT.
Note: Legal court documents are required if your dependent has been adopted by you. Eligible dependents must not be living out-of-country.
Incomplete or missing information may result in a dependent life claim being denied.

Beneficiary Designation

If no beneficiary is assigned then "ESTATE" will be assumed.
If benefits are assigned to minor children, a trustee must be appointed to act on their behalf.

Beneficiary Name (first, initial, last)	Birth Date (yy/mm/dd)	% Allocated	Relationship to Employee
Beneficiary Name (first, initial, last)	Birth Date (yy/mm/dd)	% Allocated	Relationship to Employee
Beneficiary Name (first, initial, last)	Birth Date (yy/mm/dd)	% Allocated	Relationship to Employee
Name of Trustee(s) of Dependent Children	Birth Date (yy/mm/dd)		Relationship to Employee

The Insurer merely records designations or changes beneficiaries and declines any responsibility as to their validity.
This designation applies to all life benefits under the policy.

For Quebec Residents Only

In Quebec, the designation of your spouse as beneficiary is irrevocable unless otherwise specified.

If the beneficiary is shown as irrevocable, his/her consent is required to change the beneficiary designation.

If spouse is beneficiary, designation is ☐ Revocable ☐ Irrevocable

All Statements, representations and answers made in this application are consideration for and a basis of the insurance herein requested and whether written or printed are declared to be true, full and complete.

At Western Financial Group, we know that confidentiality of personal information is important. Any information you provide to us will be kept in a group life and health benefits file. Access to your information will be limited to:

- our employees and representatives in the performance of their jobs;
- persons to whom you have granted access in writing; and
- persons authorized by law.

You have the right to request access to the personal information in your file and, if necessary, correct any inaccurate information.

Western Financial Group is focused on respecting your privacy and maintaining confidentiality of information. We have safeguards in place to protect your personal, business, and financial information which adheres to the Ten Privacy Principles as covered by the Personal Information Protection and Electronic Document Act (www.privcom.gc.ca). To learn more about Western Financial Group's commitment to privacy and security refer to our web site: www.westernfg.ca

Signature of Employee	Date	Signature of Employer	Date
-----------------------	------	-----------------------	------

Individual Insurance in Addition to Group Coverage

Are you or your dependents interested in additional insurance?	Yes	No	Life	Disability	Critical Illness
--	-----	----	------	------------	------------------

Daytime Contact Number:

Email Address:

*Premiums for individual insurance are 100% employee paid.