Accident & Sickness

Voluntary Accidental Death & Dismemberment Insurance - Application Card

Employer Section

(to be completed by the Employer)

Policy No. 9223061 Division/Unit

Employer **Capital District Health Authority**

Employee Section

(to be completed by the Employee)

Employee's Last Name First Name Initial

Amount of Principal Sum Date of Birth (M/D/Y)

Check One Plan

- ☐ Employee Only
- ☐ Employee & Family

Check One

- ☐ New Insurance
- ☐ Change in Amount
- ☐ Change of Name
- ☐ Change of Beneficiary
- ☐ Addition of Family Plan
- ☐ Deletion of Family Plan

Note - The Beneficiary Designation is revocable unless otherwise specified, however, for Quebec Residents the spousal beneficiary is irrevocable unless otherwise specified.

Beneficiary's Last Name	First Name	Initial	%	Relationship to Employee

Is Spouse to be covered "Common Law"? ☐ Yes ☐ No If Yes, please provide name.

Spouse's Last Name First Name Initial

☐ I authorize the deduction from my salary of the premiums for the insurance applied for as shown above.

☐ I have been given the opportunity to apply for this insurance but I do not desire to participate.

Employee's Signature Date (M/D/Y)

The terms and conditions governing the insurance are set out in the Group Policy which is on file with the Employer.