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beneva

APPLICATION FOR INSURANCE

Please specify: Application ◯ or Change ◯

P.O. Box 10500, Station Sainte-Foy, Quebec, QC G1V 4H6

PARTICIPANT TO COMPLETE

Identification of the Participant

Last Name	First Name	S.I.N.

General Information

Address		Work Tel.
Town/City	**Province**	**Home Tel.**

Postal Code	Email	Date of Birth (Y M D)	Language Preference	Sex at birth
			◯ English ◯ French	◯ M ◯ F

Beneficiary(ies)

If you don't designate a beneficiary, the designation is automatically: Estate of the participant. To designate a beneficiary, go to the Beneva website (beneva.ca) to complete your declaration. Otherwise, your estate will be your beneficiary. Subject to all legal provisions, you can at any time designate or revoke one or several beneficiaries for the death benefit payable under your group insurance plan.

Signature of Participant

I HEREBY AUTHORIZE MY EMPLOYER TO DEDUCT FROM MY SALARY THE PREMIUMS REQUIRED UNDER THE COVERAGE I HAVE SELECTED. I AUTHORIZE MY EMPLOYER AND BENEVA TO USE THE ABOVE INFORMATION, INCLUDING MY SOCIAL INSURANCE NUMBER, FOR ADMINISTRATIVE PURPOSES. I CERTIFY THAT ALL INFORMATION ON THIS FORM IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. FURTHERMORE, I ACKNOWLEDGE THAT I HAVE READ THE PERSONAL INFORMATION PROTECTION NOTICE ON THE REVERSE AND HAVE KEPT A COPY OF THIS FORM.

Date: Y M D Signature: _____

PARTICIPANT TO COMPLETE

Coverage

	You must select one of the following types of coverage (even if requesting an exemption)		
Health Insurance (and Dependents' Life Insurance if applicable)	INDIVIDUAL ◯	FAMILY ◯	SINGLE-PARENT (1) ◯
Exemption requested for Health Insurance ◯ (exemption does not apply to Dependents' Life Insurance)			
Dental Care Insurance (if applicable)	◯	◯	◯
Exemption requested for Dental Care Insurance ◯			

Optional Life Insurance (if applicable)	PARTICIPANT	SPOUSE
Amount of Optional Life Insurance requested	$ _____	$ _____ (2) (3)

Identification of Spouse:

LAST NAME	FIRST NAME	SEX AT BIRTH	DATE OF BIRTH (Y M D)
		◯ M ◯ F	

Non-smoker's declaration

By checking the non-smoker declaration box below, you (and your spouse, if applicable) are declaring that the following statement is true and complete. You also acknowledge that if you make a false declaration, your coverage may be voided.

"I understand that to be considered a non-smoker, I must not have smoked during the twelve (12) months prior to the application for insurance. I understand that the insurer may periodically require confirmation of non-smoker status; in such case I must be able to meet the requirements in force at that time and return confirmation within 30 days of the insurer's request, failing which I will no longer benefit from non-smoker status and the associated reduction in premiums, effective as of the date of the insurer's request."

PARTICIPANT: Non-smoker ◯ **SPOUSE:** Non-smoker ◯

NOTE (1) Single-Parent: This coverage may not be available under your group insurance plan. Please check with your plan administrator.
NOTE (2) Optional Life Insurance: Do not include the amount of Basic Life Insurance coverage.
NOTE (3) Optional Life Insurance: This coverage may not be available under your group insurance plan. Please check with your plan administrator.

Spouse and Dependent Children

Spouse's last name: _____ **First name:** _____ **Sex at birth:** ◯ M ◯ F **Date of birth:** Y M D

Already covered under a group insurance plan? ◯ No ◯ Yes, if yes → **Type of coverage:** ◯ Individual ◯ Family ◯ Single-Parent

Child's First and Last Name	Sex at birth	Date of Birth (Y M D)	Children over 18 or 21 (according to your contract) specify if full time (FT) student or disabled and name of school, college or university if applicable	
	◯ M ◯ F		◯ FT student ◯ Disabled	
	◯ M ◯ F		◯ FT student ◯ Disabled	
	◯ M ◯ F		◯ FT student ◯ Disabled	
	◯ M ◯ F		◯ FT student ◯ Disabled	
	◯ M ◯ F		◯ FT student ◯ Disabled	

PLAN ADMINISTRATOR TO COMPLETE

Plan Administrator

Name of group policyholder					Group No.
Employee No.	**Class No.**	**Annual salary**	**Date of employment (Y M D)**	**Date of eligibility (Y M D)**	**Date application submitted by employee to employer (Y M D)**
		$			

Is the participant eligible for a governmental workers' compensation program? ◯ Yes ◯ No

Employment Status

Permanent ◯

Temporary ◯ ▶ Full Time ◯ Part Time ◯ Occupation _____

I certify that this information is true and complete to the best of my knowledge.

_____ Date

Name (please print) _____

Signature of Plan Administrator _____

Tel. _____ Ext. _____

Notice regarding the protection of your personal information

Protecting your personal information is a priority for Beneva.[1] For this reason, we want to inform you that we collect, use and disclose your personal information only with your consent, unless otherwise permitted by law, and only for the time necessary to:

- identify you
- establish and update your profile, needs and objectives
- evaluate your applications and eligibility for our products and services
- provide you with advice related to your situation
- administer your contracts, as well as your products or services (e.g. pricing, underwriting, enrolment, claims processing, etc.)
- comply with legal and regulatory requirements (e.g. preventing, detecting or deterring violations, cyber threats, fraud, etc.)
- obtain your feedback on our products and services
- provide you with personalized offers and advice about our products and services based on your preferences and in compliance with the rules governing electronic and telephone communications
- conduct studies and research, including the design and application of statistical models, some of which may allow for creating or inferring new information about you

How does Beneva collect your personal information?

We may collect your personal information over the telephone, in person, and through the use of our forms and our digital platforms.

Who does Beneva share your personal information with?

For the purposes described above, and only in connection with your products and services, we share your personal information with our affiliates and distribution networks and with third parties, some of which may be located outside of Quebec and Canada.

These third parties may include:

- other financial institutions, such as insurers and reinsurers
- other organizations or entities that have information about you, including insurance, fraud or claims information
- intermediaries
- credit assessment agencies
- government departments, agencies or regulatory authorities
- employers
- claims-related service providers, such as healthcare professionals and auto repair shops
- other agents and service providers (technology services, printing and mailing services, etc.)

Please note that in all cases we ensure that they respect the protection of your personal information.

What are your rights regarding access and rectification?

You may access your personal information or request the correction of incomplete or inaccurate information. Send us a request to the following address:

Chief Privacy Officer
Beneva
2525 boulevard Laurier
Québec QC G1V 2L2
cpo@beneva.ca

For more information about our personal information protection practices, please refer to the complete version of our Privacy statement at beneva.ca/en/legal-notes-confidentiality/personal-information-protection.

Your consent for the collection, use and disclosure of your personal information is necessary in order to provide the product or service requested or offered. You have the right to withdraw your consent, but Beneva will not be able to continue providing you with its products or services.

1. The term “Beneva” refers to Beneva Inc., its affiliates, their mutuals and distribution networks. Affiliates of Beneva Inc. designates Beneva Investment Services Inc., Beneva Insurance Company Inc., L’Unique General Insurance Inc. and Unica Insurance Inc.