



# GROUP ENROLLMENT CARD

(SHORT TERM DISABILITY, LONG TERM DISABILITY,  
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT)

P.O. Box 5044, 5420 North Service Rd.  
Burlington, Ontario L7R 4C1  
**905.319.9501**

## EMPLOYER SECTION (to be completed by Employer)

NAME OF EMPLOYER	POLICY NUMBER(S)	BILLING DIVISION	CLASS NO.	REINSTATEMENT <input type="checkbox"/> YES <input type="checkbox"/> NO
OCCUPATION / TITLE	DATE EMPLOYED FULL-TIME MM   DD   YYYY	EARNINGS \$ _____	<input type="checkbox"/> Hr. <input type="checkbox"/> Wk. <input type="checkbox"/> Mth. <input type="checkbox"/> Yr.	NUMBER OF HOURS WORKED PER WEEK

## EMPLOYEE SECTION (to be completed by Employee)

EMPLOYEE NAME	DATE OF BIRTH MM   DD   YYYY	SOCIAL INSURANCE NUMBER
PROVINCE OF RESIDENCE	LANGUAGE <input type="checkbox"/> ENGLISH <input type="checkbox"/> FRENCH	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
DO YOU HAVE DEPENDENTS? <input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD(REN)

**BENEFICIARY DESIGNATION** *To name more than one beneficiary or to name a contingent beneficiary, ask your plan administrator for assistance.*  
Applicable to Life or AD&D coverages

Beneficiary's Last Name	First Name	Initial	%	Relationship
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If none of the above is living then pay \_\_\_\_\_

### FOR RESIDENTS OF QUEBEC ONLY:

A spousal beneficiary designation is irrevocable unless you make the designation revocable by checking here.  
REVOCABLE

I hereby apply for the Group Insurance coverage for which I am now or may later become eligible and authorize my Employer to deduct the required contribution, if any, from my pay.  
I agree that any insurance issued as a result of this application shall take effect on the date I am actively employed on a full-time basis, otherwise on the date I return to full-time active employment, subject to approval by the Company and any waiting period pertinent to my Employer's plan. The company shall not be liable for any claim commencing prior to the effective date of insurance.  
I hereby authorize the company to use my Social Insurance Number specifically for my insurance file identification, any tax reporting purposes, and all other matters pertaining to my Group Insurance plan.  
Employee's Signature \_\_\_\_\_ Date (mm / dd / yyyy) \_\_\_\_\_

For Head Office Use Only	Occ Code	Date Received Month   Day   Year	Effective Date Month   Day   Year	Cert No(s)	Approved By
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Unum is the marketing brand for: **The Paul Revere Life Insurance Company • Provident Life and Accident Insurance Company • Unum Life Insurance Company of America**

White - Unum      Yellow - Employer

