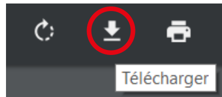
Steps to complete the form

1

Click on the download button for save the form on your computer.



2

Fill in the fields of the form and save your information before submitting it to us.

UV INSURANCE

MEMBERSHIP REQUEST
GROUP INSURANCE

CERTIFICATE (FOR INSURER ONLY)

EMPLOYER'S NAME	GROUP	DIVISION	EMPLOYEE ID.	S.I.N	EMPLOYEE'S E-MAIL (REQUIRED)

EMPLOYEE'S LAST NAME	FIRST NAME	LANGUAGE ☐ FR. ☐ EN.	GENDER ☐ M ☐ F	DATE OF BIRTH Y M D

EMPLOYEE'S ADRESS
N° STREET APT CITY PROVINCE POSTAL CODE

DATE OF EMPLOYMENT Y M D	OCCUPATION	CLASS	SALARY $	☐ ANNUAL ☐ WEEKLY ☐ MONTHLY ☐ HOURLY RATE # HOURS / WEEK	PHONE NUMBER

CIVIL STATUS : ☐ SINGLE ☐ SEPARATED ☐ DIVORCED ☐ MARRIED ☐ CIVIL UNION DATE OF COHABITATION'S BEGINNING : Y M D

COVERAGE (IF YOU HAVE CHOSEN A PROTECTION FOR YOUR DEPENDANTS, PLEASE FILL IN THE DEPENDANTS SECTION)

DESIRED PROTECTION : ☐ INDIVIDUAL WITH DEPENDANTS LIFE ☐ INDIVIDUAL ☐ COUPLE ☐ FAMILY ☐ SINGLE PARENT

IS YOUR SPOUSE COVERED UNDER ANOTHER INSURANCE PLAN : **SPOUSE'S COVERAGE :**

HEALTH CARE :	☐ YES	☐ NO	☐ SINGLE	☐ COUPLE	☐ FAMILY	☐ SINGLE PARENT
DENTAL CARE :	☐ YES	☐ NO	☐ SINGLE	☐ COUPLE	☐ FAMILY	☐ SINGLE PARENT

EXEMPTION REQUEST :

☐ FOR MYSELF AND MY DEPENDANTS : ☐ HEALTH CARE AND DRUG INSURANCE BENEFIT ☐ DENTAL CARE BENEFIT
☐ FOR MY DEPENDANTS ONLY : ☐ HEALTH CARE AND DRUG INSURANCE BENEFIT ☐ DENTAL CARE BENEFIT
SPOUSE INSURER NAME : SPOUSE PLAN NUMBER : SPOUSE CERTIFICATE NUMBER :

DEPENDANTS

* PROOF OF FULL-TIME STUDY REQUIRED
** PROOF REQUIRED

LAST NAME	FIRST NAME	RELATIONSHIP	SEX	DATE OF BIRTH	FULL-TIME STUDENT (AGE 21 OR MORE) *	DISABLED DEPENDANT **
		☐ SPOUSE ☐ CHILD	☐ M ☐ F	Y M D		
		☐ SPOUSE ☐ CHILD	☐ M ☐ F	Y M D	☐ YES ☐ NO	☐ YES ☐ NO
		☐ SPOUSE ☐ CHILD	☐ M ☐ F	Y M D	☐ YES ☐ NO	☐ YES ☐ NO
		☐ SPOUSE ☐ CHILD	☐ M ☐ F	Y M D	☐ YES ☐ NO	☐ YES ☐ NO

BENEFICIARY IN CASE OF DEATH **NOTE:** IN QUEBEC, UNLESS OTHERWISE STIPULATED, THE DESIGNATION OF A LEGAL SPOUSE IS IRREVOCABLE. ANY OTHER DESIGNATION IS REVOCABLE.

LAST NAME :	FIRST NAME :	RELATIONSHIP :	%	☐ REVOCABLE ☐ IRREVOCABLE
LAST NAME :	FIRST NAME :	RELATIONSHIP :	%	☐ REVOCABLE ☐ IRREVOCABLE

AUTHORIZATION

I AUTHORIZE ANY HEALTH PROFESSIONAL AND ANY PUBLIC OR PRIVATE INSTITUTION OF HEALTH AND SOCIAL SERVICES, ANY INSURANCE COMPANY, THE MEDICAL INFORMATION BUREAU (MIB), PERSONNAL INFORMATION AGENTS OR INVESTIGATION AND SECURITY AGENCIES, MY EMPLOYER OR FORMER EMPLOYER AND ANY PUBLIC BODY HOLDING INFORMATION TO SEND SUCH INFORMATION TO THE INSURER, THE REINSURERS AND THEIR SERVICES' PRODIVERS IF NECESSARY FOR ANY RISK ASSESSMENTS OR CLAIM STUDIES. I ALSO AUTHORIZE MY INSURER OR HIS REINSURERS TO EXCHANGE WITH OTHER INSURERS OR PEOPLE THAT I HAVE GIVEN AS A REFERENCE, THE PERSONAL INFORMATION CONTAINED IN THIS APPLICATION AND TO INVESTIGATE THEM WHEN ASSESSING THE RISKS OR WHEN STUDYING CLAIMS. I ALSO AUTHORIZE UV INSURANCE (THE UNION LIFE, MUTUAL ASSURANCE COMPANY) TO MAKE A BRIEF REPORT OF MY PERSONAL HEALTH INFORMATION TO THE BUREAU OF MEDICAL INFORMATION (MIB). I AGREE TO COOPERATE AND SIGN ANY SPECIFIC AUTHORIZATION DOCUMENT THAT MAY BE REQUIRED OR NECESSARY FOR THE INSURER TO OBTAIN INFORMATION TO EVALUATE PROPERLY THE SITUATION. A COPY OF THIS AUTOHORIZATION OR THIS CONSENT HAS THE SAME VALUE AS THE ORIGINAL.

IN THE EVENT OF MY DEATH, I EXPRESSLY AUTHORIZE THE BENEFICIARY, HEIR OR OFFICIAL LIQUIDATOR OF MY SUCCESSION TO PROVIDE TO THE INSURER, HIS REINSURERS AND THEIR SERVICES' PROVIDERS UPON REQUEST, ANY INFORMATION OR NECESSARY AUTHORIZATIONS REQUIRED FOR THE STUDY OF THE DEATH CLAIM OR TO OBTAIN ANY SUPPORTING DOCUMENTATION.

I REQUEST TO JOIN MY EMPLOYER'S GROUP INSURANCE CONTRACT ISSUED BY UV INSURANCE AND I ACKNOWLEDGE HAVING READ THE NOTICE ON THE ESTABLISHMENT OF A PERSONAL FILE INDICATED AT THE BOTTOM OF THIS PAGE.

I AUTHORIZE MY EMPLOYER TO DEDUCT FROM MY SALARY THE REQUIRED PREMIUM IN REFERENCE TO THE PROTECTIONS I HAVE SELECTED AND TO UPDATE THE NECESSARY INFORMATION FOR THE ADMINISTRATION OF THE INSURER'S FILE. ALL SUBMITTED INFORMATION CONSTITUTES AN AFFIRMATIVE GUARANTEE FROM MY PART.

DATE ______________________ **EMPLOYEE'S SIGNATURE** **X** ______________________

TO BE COMPLETED BY THE POLICYHOLDER ADMINISTRATOR

EMPLOYEMENT STATUS ☐ PERMANENT FULL TIME ☐ PERMANENT PART-TIME ☐ TEMPORARY FULL TIME ☐ TEMPORARY PART-TIME	ELIGIBILITY DATE Y M D	REMARKS
POLICY ADMINISTATOR NAME :	PHONE NUMBER	

I CERTIFY THAT THE ABOVE INFORMATION IS ACCURATE AND COMPLETE

DATE **X** SIGNATURE OF THE POLICY ADMINISTRATOR

NOTICE RELATING TO THE CONSTITUTION OF A FILE

ALL PERSONAL INFORMATION CONTAINED IN THIS DOCUMENT WILL BE KEPT IN A GROUP INSURANCE FILE WITH UV INSURANCE AND IN YOUR PERSONAL HEALTH FILE WITH SERVICES PROVIDERS OF THE INSURER. THE INFORMATION WILL BE USED TO EVALUATE THIS REQUEST FOR GROUP INSURANCE AND TO PROCESS ANY CLAIM. ONLY EMPLOYEES, AUTHORIZED AGENTS AND SERVICES PROVIDERS DULY AUTHORIZED BY UV INSURANCE WILL HAVE ACCES TO THIS INFORMATION IN THE COURSE OF BUSINESS TRANSACTIONS. YOUR GROUP INSURANCE FILE WILL BE IN CUSTODY OF UV INSURANCE AT UV INSURANCE'S OFFICE. WITH A WRITTEN REQUEST AND A 30 DAYS NOTICE, YOU HAVE THE RIGHT TO REVIEW THE PERSONAL INFORMATION CONTAINED IN YOUR FILE AND IF NECESSARY, A RECTIFICATION REQUEST CAN BE MADE IN ACCORDANCE WITH THE ACT RESPECTING THE PROTECTION OF PERSONAL INFORMATION IN THE PRIVATE SECTOR. PLEASE ADDRESS YOUR REQUEST TO UV INSURANCE, TO THE ATTENTION OF THE PRIVACY OFFICER, P.O. BOX 696, DRUMMONDVILLE, QC J2B 6W9.

560 (2020-11) **RETURN THE ORIGINAL AND KEEP A COPY**

UV Insurance is a business name and trademark of The Union Life Mutual Assurance Company.