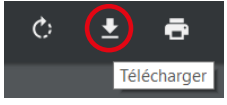
# Steps to complete the form

**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

GROUP INSURANCE

# Application for Insurance

Certificate

## Section A – Identification

**To be completed by the employee**

1. Last name _____ First name _____
2. Gender ☐ M ☐ F Date of birth Y Y Y Y M M D D
3. Language ☐ English ☐ French Phone number ___ - ___ - ___ ☐ Home ☐ Mobile ☐ Office
4. Email address (required) _____
5. Address (number, street, apt.) _____
   City _____ Province _____ Postal code _____
6. Marital status ☐ Single ☐ Married ☐ Common-law partner → Cohabitation start date Y Y Y Y M M D D

**To be completed by the plan administrator**

1. Employer _____ Group # _____ Billing unit _____ Class _____
2. Reference number _____
3. Occupation _____ Employment start date Y Y Y Y M M D D
4. Salary $_____ ☐ Annual ☐ Weekly ☐ Monthly ☐ Hourly rate Hours per week _____
5. Employment status ☐ Permanent full-time ☐ Temporary full-time* ☐ Permanent part-time ☐ Temporary part-time* ☐ Occasional* ☐ Seasonal*

   Eligibility date Y Y Y Y M M D D

   Notes _____

* Refer to contract if eligible

## Section B – Coverage

**Desired coverage:**

| | | | | | |
|---|---|---|---|---|---|
| 1. Life insurance for dependants | ☐ N/A | ☐ Couple | ☐ Single parent | ☐ Family | |
| 2. Health insurance | ☐ Individual | ☐ Couple | ☐ Single parent | ☐ Family | ☐ Exemption* |
| 3. Dental insurance (if applicable) | ☐ Individual | ☐ Couple | ☐ Single parent | ☐ Family | ☐ Exemption* |

***** To be exempted, you must have similar coverage under another group insurance plan.
If this is the case, please provide us with the information below:

Is your spouse covered under another plan for:

| | | | Spouse's coverage: | | | |
|---|---|---|---|---|---|---|
| ↳ Health insurance | ☐ No | ☐ Yes → | ☐ Individual | ☐ Couple | ☐ Single parent | ☐ Family |
| ↳ Dental insurance | ☐ No | ☐ Yes → | ☐ Individual | ☐ Couple | ☐ Single parent | ☐ Family |

If your group insurance plan is a **modular plan**, indicate the name of the desired module _____

Terms of the chosen option are applicable to the employee and, if applicable, to their dependants. The same option is applicable to both health and dental insurance. The insured member must keep the chosen option throughout the term provided in their contract. Please refer to the booklet to consult all the rules concerning module changes.

## Section C – Dependants

Make sure you have obtained consent from your dependants before collecting their personal information and completing this section.

| Last name, first name | Relationship | | Gender | | Date of birth | Full-time student (age 21 or older) | Disabled* |
|---|---|---|---|---|---|---|---|
| | Spouse | Child | M | F | | | |
| _____ | ☐ | ☐ | ☐ | ☐ | Y Y Y Y M M D D | ☐ | ☐ |
| _____ | ☐ | ☐ | ☐ | ☐ | Y Y Y Y M M D D | ☐ | ☐ |
| _____ | ☐ | ☐ | ☐ | ☐ | Y Y Y Y M M D D | ☐ | ☐ |
| _____ | ☐ | ☐ | ☐ | ☐ | Y Y Y Y M M D D | ☐ | ☐ |
| _____ | ☐ | ☐ | ☐ | ☐ | Y Y Y Y M M D D | ☐ | ☐ |

* Proof required

EN-5016A (2024-05)

## Section D – Beneficiaries

In the event of my death, I authorize the beneficiary, heir or executor of my estate to provide UV Insurance and its reinsurers with the information required to investigate the death claim, including supporting documents such as a death certificate or identification.

| Last name, first name | Relationship | Date of birth | Percentage | Irrevocable | Revocable |
|---|---|---|---|---|---|
| | | Y Y Y Y M M D D | % | ☐ | ☐ |
| | | Y Y Y Y M M D D | % | ☐ | ☐ |
| | | Y Y Y Y M M D D | % | ☐ | ☐ |
| | | Y Y Y Y M M D D | % | ☐ | ☐ |

**Important:** In Quebec, the designation of a spouse with whom the participant is legally married or in a civil union as beneficiary is irrevocable unless otherwise stipulated. In the event of death or divorce, revocation is automatic.
**Attention:** If you complete this form by hand, please ensure that you write legibly and do not cross out or use correction fluid. Otherwise, the beneficiary designation will not be valid and you will have to complete the form again.

### Trustee appointment

**For Quebec:** The provisions of the Civil Code apply. **Do not** complete this section.
**For all other provinces, except Quebec:** Complete this section **only** if you have designated a minor beneficiary.

The designated trustee will receive for the minor beneficiary any amounts under the plan established by UV Insurance. The receipt of such amounts by the trustee constitutes a release for UV Insurance. A designation remains valid until a new trustee is appointed or the beneficiary reaches the age of majority, whichever comes first.

First name of the trustee _____ Last name of the trustee _____

## Section E – Direct Deposit

I hereby authorize UV Insurance to deposit my group insurance claim payments into my personal bank account identified on the attached void cheque. I certify that the foregoing information is accurate and I commit to inform UV Insurance of any changes. I accept that the agreement may be cancelled by UV Insurance or by myself upon written notice.

A specimen cheque marked "VOID" must be sent to UV Insurance by the secure site or by mail to the address indicated at the bottom of this form.

## Section F – Collection, Use and Disclosure of Personal Information

UV Insurance collects personal information about you and your dependants. The information we collect, retain, and use allows us to verify your identity, validate your eligibility for our products and services, process your claims, administer your file, and meet legal requirements. Only duly authorized employees, agents, and service providers will have access to this information in the normal course of business.

In the event that any of said personal information is inaccurate, incomplete or unclear, you may request that it be corrected by contacting our customer service. You may withdraw your consent to the disclosure or use of your personal information at any time by sending a request to the UV Insurance Privacy Officer at the following address: 1990 Jean-Berchmans-Michaud street, Drummondville (QC) J2C 7G7. Withdrawal of your consent may have legal or contractual consequences. For example, UV Insurance may not be able to process a request or claim. We wish to inform you that the use of e-mail as a means of communication to transmit a document or text does not guarantee the protection or confidentiality of the information contained in the e-mail. We invite you to use your "My Universe" member portal.

For more details, please consult our privacy policy at www.uvinsurance.ca/privacy-policy.

## Section G – Declarations and Authorizations

I declare that the information contained in this application is complete and true. I consent to the use of this information in the preparation of my insurance file, and I acknowledge that any misrepresentation or omission may result in the termination of all or part of my group insurance coverage, or even the denial of certain benefits payable under this contract.

I hereby apply for the group insurance contract issued to my administrator by UV Insurance, and acknowledge that I have read and understood of the information set out in section F above concerning the collection, use, and disclosure of personal information.

I authorize my employer or the administrator of my group insurance plan to communicate my personal information and that of my dependants to UV Insurance for the purpose of administering my file.

A photocopy of these declarations and authorizations has the same value as the original.

**X** _____ Y Y Y Y M M D D
Member's signature

## Section H – Plan Administrator's Signature

I certify that the statements made above are, to the best of my knowledge, complete and true.

**X** _____ _____ Y Y Y Y M M D D
Plan administrator's signature Plan administrator's print name

Title _____ Phone number ___-___-____

P.O. Box 696, Drummondville (Quebec) J2B 6W9 ■ Phone: 819-478-1315 ■ Toll-free: 1-800-567-0988 ■ Fax: 819-474-1990


EN-5016A (2024-05)