Group Life Insurance – Equitable Life

Group Life Insurance is Mandatory at BREB. Member's Beneficiaries will receive a $30,000.00 Benefit should the Member pass away.

Completing the Form

IMPORTANT – Please only complete the YELLOW HIGHLIGHTED AREAS
- Do Not Date the form at the bottom of page 3
- Do Not fill in the employment start date as it is dependant on when your application has been processed.

Beneficiary Information; must add up to 100% (shares); if there is more than two beneficiaries contact the board office so that we are able to supply you with additional form. If no Beneficiaries are named the benefit will go to the Member's Estate

Contingent Beneficiaries: Should something happen to yourself and your Beneficiaries the Contingent Beneficiaries receive the benefit. Contingent Beneficiaries should also add up to 100% (shares).

Trustee Information – Only required if any of the Beneficiaries/Contingent Beneficiaries are under the age of 18. The Trustee CANNOT be one of the people already named on the form.

If there are any errors made on the form please reprint it and fill it out again. Equitable Life will not accept any forms that have crossed out or covered over information.

Equitable Life of Canada®

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TF 1.800.265.4556 **Fax** 519.883.7403
www.equitablehealth.ca

NEW PLAN MEMBER GROUP INSURANCE APPLICATION (NO DEPENDENT BENEFITS)

1. PLAN SPONSOR INFORMATION This section to be completed by the Plan Sponsor or Group Plan Administrator/Insurer

Name of Policyholder
Brampton Real Estate Board

Name of Division/Subsidiary or Affiliate where the Plan Member works

Group Policy Number	Division Number	Class
812190	001	A

Plan Member's name (first, middle, last) ☐ Male ☐ Female

Certificate Number	Occupation
	Sales

Date Employed Full Time (MM/DD/YYYY)

Earnings: $ 0.01 ☐ Hour ☐ Week ☐ Month ☐ Year ☑ Other:

If hourly earnings – standard hours worked per week	Billing Sort Code (If applicable)
40	

2. PLAN MEMBER INFORMATION This section to be completed by the Plan Member

Plan Member's Date of Birth (MM/DD/YYYY)

Plan Member's address

Street	City

Province	Postal Code

Preferred Language ☑ English ☐ French

Plan member's email address

3. PLAN MEMBER BENEFICIARY INFORMATION This section to be completed by the Plan Member

NOTE: If no beneficiary is appointed, the proceeds shall be paid as required by provincial law. If more than one beneficiary is appointed, proceeds will be payable in equal shares, unless otherwise indicated. The insured Plan Member can change the appointed beneficiary at any time.

Name of Primary Beneficiary (first, middle, last)	☐ Male ☐ Female	Relationship to Plan Member:	% Share
Name of Primary Beneficiary (first, middle, last)	☐ Male ☐ Female	Relationship to Plan Member:	% Share

NEW PLAN MEMBER GROUP INSURANCE APPLICATION (NO DEPENDENT BENEFITS)

3. PLAN MEMBER BENEFICIARY INFORMATION Continued

If the above Primary Beneficiary(ies) pre-deceases me, to:

Name of Contingent Beneficiary (first, middle, last)	☐ Male ☐ Female	Relationship to Plan Member:	% Share
Name of Contingent Beneficiary (first, middle, last)	☐ Male ☐ Female	Relationship to Plan Member:	% Share

NOTE: If both the Primary Beneficiary(ies) and Contingent Beneficiary(ies) are deceased, the proceeds will be paid as required by provincial law. If there are additional Primary and/or Contingent Beneficiaries, please sign, date and attach a note to this form with the beneficiary information.

NOTE: For Quebec residents, designating your spouse as beneficiary is irrevocable unless you make the designation revocable. An irrevocable beneficiary designation cannot be changed without the written consent of the irrevocable beneficiary. A revocable beneficiary designation can be changed at any time without the consent of the revocable beneficiary. I elect to make my spouse (married or civil union) designation: ☑ Revocable

If the beneficiary is under the age of majority at the time of my death, proceeds of the said policy shall be payable to the following except in Quebec:

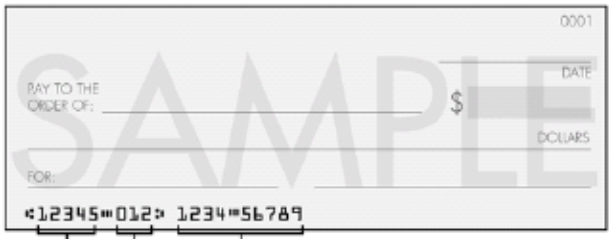
Name of Trustee _____ ☐ Male ☐ Female
(Please Print - First, Middle, Last)

Relationship to Plan Member _____

4. PLAN MEMBER DIRECT DEPOSIT INFORMATION This section to be completed by the Plan Member

I authorize Equitable Life to deposit Group Claim payments directly into my bank account.

Bank's Name: NOT APPLICABLE		
Account Number: NOT APPLICABLE	Institution Code: N/A	Bank Transit Number: N/A



Please attach a VOID cheque or Stamped bank document to process your direct deposit.

5. PLAN MEMBER CONFIRMATION OF PROVINCIAL HEALTH PLAN COVERAGE This section to be completed by the Plan Member

I am covered for Provincial Health Plan: ☑ Yes ☐ No

If no, date your Provincial Health coverage will be in effect (MM/DD/YYYY)

The personal information willingly provided by me to my Plan Sponsor, the independent broker/sales advisor and/or Equitable Life, collected on this Application and held in their files, will be used by Equitable Life for the purposes of underwriting, servicing, administration, claims processing and adjudication related to this Application, the Group Insurance Policy and all benefits there under, and any supplementary documents. I understand and authorize that for the above purposes the personal information on file is accessible to, and may be exchanged with, authorized employees of, and relevant third parties retained by Equitable Life, its sales and distribution network, participating reinsurer(s), other insurance companies, investigative organizations, health care providers, including, but not limited to pharmacies, physicians and dentists and any other person or party whom I authorize. I understand that all claims made under the Group Insurance Policy are submitted through me as insured Plan Member. I therefore authorize Equitable Life to exchange information about these claims with me or any person acting on my behalf, as deemed necessary for the purposes of confirming eligibility and assessing and managing the claim.

I certify that all of the information given on this form is true, correct and complete.

Date: _____ Plan Members Signature: _____

(MM/DD/YYYY)