UCDA Employee Benefits

Non-Medical Application Form

FOR OFFICE USE ONLY
UCDA MEMBER #

The completion of this Enrolment Application does not guarantee insurance coverage. If space is insufficient for any question, print the answer on additional paper, sign, date and attach the paper to this form.

Employer: _____

Part 1 - Applicant Information:

Last Name: _____ First Name: _____ Middle Initial: ____

Street: _____ Unit/Apt Number: _____

City: _____ Prov: _____ Postal Code: _____ Email: _____

Home Phone: _____ Birth date (mmm/dd/yy): _____ Gender: ☐ M ☐ F

Business Phone: _____ Occupation: _____ Annual Income: _____

Place of Birth (Country/Province): _____ Hire Date (mmm/dd/yy):_____

Part 2 - Dependent Information: ☐ Single ☐ Family

Please complete the following for your Spouse and/or Dependent Children to be covered

	Name of Dependent (First Name & Last Name)	Date of Birth (mmm/dd/yy)	Relationship to Applicant	Gender M or F
1				
2				
3				
4				

1. Do you have dependents listed above who are over 18 and attending full-time education? ☐ Yes ☐ No
   If "yes", proof of enrolment in full-time accredited facility is required. Please submit current documentation with this application. Coverage is limited to dependents age 25 or under.

2. Are any of the dependents listed above covered under another group health and dental plan? ☐ Yes ☐ No
   If "yes", please check which ones: ☐ ALL ☐ Dependent #1 ☐ Dependent #2 ☐ Dependent #3 ☐ Dependent #4

Part 3 - Waiver of Benefits:

I am covered under my spouse's benefits plan, and wish to decline health and dental benefits through the UCDA Benefits plan ☐ Spouse's insurer _____ Plan # _____

Part 4 - Beneficiary Election:

To designate more than one beneficiary, please use form U-105.

First name: _____ Middle Name: _____ Last Name: _____

Relationship _____ Age of beneficiary _____ If under age 18, trustee is: _____

Authorization, Declaration and Acknowledgement

I hereby declare that the information provided is complete and true to the best of my knowledge. I understand that this Application Form is part of insurance coverage provided through the Used Car Dealer's Association of Ontario. I authorize The Capital Group Insurance and their representatives to share my personal information disclosed on this application with any other party providing insurance protection under the UCDA Plan, including but not limited to ETFS, ACE-INA Life Insurance, Unistar International Inc., Canadian Benefit Administrators, Western Life Insurance Co. and Desjardins Financial, for the purpose of underwriting my participation.

I hereby declare that I am actively engaged in my occupation on a full-time basis. A photocopy of this authorization shall be as valid as the original.
Your Privacy is Protected: The insurance coverage you are applying for is underwritten by various insurers and administered by The Capital Group Insurance Inc. The insurers and The Capital Group Insurance Inc. collect, use and disclose the personal information which you give for the purpose of providing you with insurance services. Your information may be disclosed to others in the medical, investigative and insurance fields as necessary to underwrite and administer the insurance and pay benefits. Full details regarding how your privacy is protected can be obtained by asking your representative for a copy of our privacy policy.

Signature of Applicant: _____ Date: _____

Please submit your completed application to **The Capital Group Insurance:**
14-3650 Langstaff Rd., Suite 123, Woodbridge, ON L4L 9A8 Phone: 1-866-476-8722 Fax: 1-888-416-8267

THE CAPITAL GROUP Insurance Inc.