EMPLOYEE BENEFITS LTD.

Application for Group Benefits

A & W REGIONAL FRANCHISE ASSOCIATION

☐ New Application ☐ Reinstatement

Employee Waiting Period: ☐ 0 months ☐ 6 months ☐ 12 months

Employee's Surname	First Name	Middle Initial	Social Insurance Number	Gender ☐ Male ☐ Female	Birthdate YY MM DD	Policy Contract Number and Division

Registered Name of Employer	Name of Restaurant	Number of Hrs. Worked per Week	Date Employed Full Time YY MM DD	Effective Date

Occupation of Employee	Employee Earnings $	Hr / Wk / Bi Wk / Mo / Yr	Employer Contribution %	Employee Address

Class 1 = Salaried Employee: Benefits: Life, AD&D, LTD, Health & Dental
Class 2 = Hourly Employee: Benefits: Life, AD&D, LTD, Health & Dental
Class 3 = Entry Level Hourly Employee: Benefits: Life, AD&D, Health & Dental
Class 4 = Salaried Employee: Benefits: Health & Dental Only
Class 5 = Hourly Employee: Benefits: Health & Dental Only

Class Code

Beneficiary Designation -- I hereby designate as revocable beneficiary in the event of my death:

Name ______________________ Relationship ______________________

Trustee designation for beneficiary under legal age: *I hereby appoint as trustee to receive any amount due my beneficiary under legal age and authorize such trustee to spend all or any portion of such amount and the income from it for the maintenance and education of such minor.*

Name of Trustee ______________________

City ______________________

Prov. ____ Postal Code ____________

If previously covered for these benefits with another employer or insurance company complete this line

Group Number of Previous Coverage	Social Insurance Number	Termination Date YY MM DD	*Name of Insurance Company and Benefits Covered*

Complete this section if you have eligible dependents

Note -- If you do not want your dependents covered for eligible benefits, complete a "*Waiver of Group Benefits*" Card

List Dependents, oldest first

Dep. #	First Name	Initial	Surname	Gender M/F	Birthdate YY	MM	DD	*Indicate if student or handicapped. Include name of school/university or nature of handicap*	S/H
01	Spouse								
02	1st Child								
03	2nd Child								
04	3rd Child								
05	4th Child								
06	5th Child								
07	6th Child								

I authorize the use of my Social Insurance Number for tax reporting and identification and benefit administration. I authorize my employer to deduct required contributions from my earnings (if applicable), and I agree to the conditions of the contract between my employer and the Insurance Company(ies). I also agree that the information included in this application is true and complete.

____
Signature of Employee

____
Date Signed

Waiver Card Attached ☐ Yes ☐ *No*

Please TYPE or PRINT clearly in ink

Please complete and return by Fax or Mail to:

HMR EMPLOYEE BENEFITS LTD.
220-2186 Oak Bay Ave.
Victoria, BC
V8R 1G3
Tel: (250) 592-4614
Toll Free: 1-888-592-4614
Fax: (250) 592-4953