CB Benefits

Canadian Baptist Benefits Plan

Election Form – Benefits Selection

Please print clearly, both sides, in INK – sign and date form. Make a copy for your records.

1. Plan Administrator

Plan Number:	Canada Life Division #:	Benefit Class:
Plan Administrator: ❑ CBM ❑ CBOQ ❑ CBWC ❑ FBU	Plan Member ID:	
Employer:	Date of Employment (yyyy/mm/dd):	
Effective Date of Coverage (yyyy/mm/dd):	Province of Residence:	Province of Employment:
Occupation:	Earnings: $ per ❑ year ❑ month ❑ week ❑ hour	

2. Member Information

Member's Name (first, middle initial, last):		Gender: ❑ Male ❑ Female
Address (street number and name, apartment or suite):		
City:	Province:	Postal Code:
Date of Birth (yyyy/mm/dd):	Language: ❑ English ❑ French	
Email Address:		

Marital Status: ❑ Single ❑ Married Family Status for Benefit Coverage: ❑ Member only ❑ Member + 1 ❑ Member + 2 or more

Spouse Details

Complete this section.	Spouse's Name (first, last):	Date of Birth (yyyy/mm/dd):	Gender: ❑ Male ❑ Female
	Is your spouse covered for health or dental care benefits by his/her employer's plan? ❑ Yes ❑ No Spouse's Insurer:	If yes, please indicate spouse's coverage: Health plan ☐ Family ☐ Single ☐ Vision care Dental plan ☐ Family ☐ Single	

Dependent Children Details

Complete this section. If you have more than three dependents, please photocopy this blank page to include additional details.	Child's Name (first, last):	Date of Birth (yyyy/mm/dd):	Gender:	Student*:	Overage** disabled child:
			❑ Male ❑ Female	❑ Yes ❑ No	❑ Yes ❑ No
			❑ Male ❑ Female	❑ Yes ❑ No	❑ Yes ❑ No
			❑ Male ❑ Female	❑ Yes ❑ No	❑ Yes ❑ No

* A student is a child age 22 or over but under age 25, who is a full-time student attending an educational institution recognized by the CRA, as long as the child is not married or in any other formal union and is entirely dependent on you for financial support.

** To enrol an overage disabled child, contact your plan administrator within 31 days of the date the dependent reaches the age limit (22).

3. Flexible Benefits – Canada Life Policy 156241

Your benefit selections will remain in effect until Jan 1 of the next enrollment year, which occurs on even years only (2026,2028,2030 etc.).

Choose only one plan: ○ STANDARD Plan ○ ENHANCED Plan ○ PREMIUM Plan

4. Optional Accidental Death & Dismemberment Insurance – CHUBB Policy OE1058101

Units of $10,000 to a maximum of $250,000	Amount Requested: $

Choose only *one* plan: ❑ Member Only
❑ Member + Dependents

No evidence of insurability is required for Optional Accidental Death & Dismemberment Insurance.

5. Beneficiary Designation

By completing this form, I revoke all previously nominated beneficiary designations and make the following nominations, where permitted by law.

Complete each section for any benefits for which you are applying. If your current beneficiary nomination is irrevocable, your current beneficiary must agree to revoke their rights by completing a Consent by Beneficiary Form. If you need more space for additional beneficiaries, please photocopy this blank page.

Beneficiary for Member BASIC Life Insurance
Canada Life Policy 156241

Complete this section.

Name (first, last)	Date of Birth (yyyy/mm/dd)	Relationship to you	Percentage (must total 100%)

In Quebec, if you name your legal spouse (married or civil union) as the beneficiary, this beneficiary will be irrevocable unless you check the revocable box. ☐ Revocable beneficiary

Beneficiary for Member BASIC Accidental Death & Dismemberment (AD&D) Insurance
CHUBB Policy AB1051801

Complete this section.

Name (first, last)	Date of Birth (yyyy/mm/dd)	Relationship to you	Percentage (must total 100%)

In Quebec, if you name your legal spouse (married or civil union) as the beneficiary, this beneficiary will be irrevocable unless you check the revocable box. ☐ Revocable beneficiary

Beneficiary for Member OPTIONAL Accidental Death & Dismemberment (AD&D) Insurance (if applicable)
CHUBB Policy OE1058101

Complete this section only if you are applying for Optional AD&D coverage.

Name (first, last)	Date of Birth (yyyy/mm/dd)	Relationship to you	Percentage (must total 100%)

In Quebec, if you name your legal spouse (married or civil union) as the beneficiary, this beneficiary will be irrevocable unless you check the revocable box. ☐ Revocable beneficiary

Nomination of trustee for minor beneficiaries other than Quebec residents

If you wish to designate minor child(ren) as beneficiary(ies), a trustee must be designated.

Any payments becoming due while the beneficiary(ies) are a minor* are to be made to

_____ as trustee, or failing such trustee to the duly appointed guardian of such minor children as trustee. Payment to the trustee will discharge the insurer.

*A minor is a child who has not reached the age of majority as defined by provincial legislation.

Appointing minor beneficiaries for Quebec residents

In Quebec, any amount payable to a minor beneficiary during his or her minority will be paid to the minor child's tutor (surviving parent or legal guardian). A lawyer or notary should be consulted.

Any payments becoming due while the beneficiary(ies) are a minor* are to be made to

_____

as the minor child's tutor. Payment to the minor child's tutor will discharge the insurer.

*A minor is a child who has not reached the age of 18 years.

Privacy, Authorizations, Declarations

The personal information the plan administrator collects concerning you and your dependents is kept in strict confidence and used only for the purposes you have authorized. Your personal file is kept at the plan administrator's offices. You have the right to request access to your personal information, and, if necessary, correct any inaccurate information and/or make changes to current information whenever necessary. In order to do so, send a written request to the plan administrator.

Access to your personal information will be limited to the plan administrator and insurers in the performance of their jobs, individuals to whom you have consented access, and persons authorized by law. For the purposes of audits and administrative reporting, the plan administrator may release your Employer/Policyholder statistical information without personal identifiers.

I HEREBY APPLY for the benefits which I am or may become eligible for, subject to any waiver indicated, under my Employer's/Policyholder's group insurance plan and CONFIRM that the information contained in this form is true and complete to the best of my knowledge.

If any contributions are required to be made by me with respect to my group benefits, I AUTHORIZE my employer to make any required deductions from my earnings and remit same to the applicable insurance provider.

I AGREE that a photocopy of this Confirmation/Authorization shall be as valid as the original.

Plan Member's Signature X	Date (yyyy/mm/dd)
Plan Member's Name (please print)	