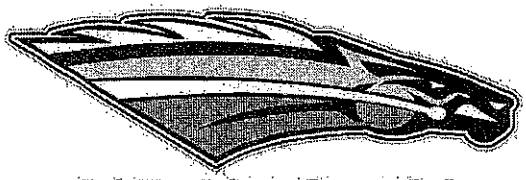
STEELHORSE



FREIGHT

BENEFITS

ENROLMENT FORM

Certificate # _____

PLEASE PRINT AND COMPLETE EACH SECTION CLEARLY IN INK.
REMIT SIGNED ORIGINAL TO RWAM AND KEEP A COPY FOR YOUR RECORDS.

EMPLOYER DATA

☐ New
☐ Reinstatement

Employer _____ Group# _____ Div.# ____ Class _____

Permanent Full-time Hire Date _____ (yy/mm/dd)
(Reinstatements indicate date of re-hire)

Description of Occupation _____

Earnings _____
(Excluding Bonus/Dividend/Overtime Income)

☐ Salary (annual) ☐ Bi-Weekly ☐ Weekly
☐ Hourly ☐ Monthly

Hours worked (per week) _____

EMPLOYEE STATEMENT

You and your dependents must be insured under your Provincial Benefit Plan in order to participate in RWAM's group insurance plan.

Employee's Surname _____ First Name _____

Date of Birth _____ (yy/mm/dd)

Sex ☐ Female ☐ Male

Address _____

Marital Status
☐ Single ☐ Common-law* ☐ Separated ☐ Married ☐ Divorced ☐ Widowed

*If Common-law, indicate date co-habitation began _____ (yy/mm/dd)

☐ **SINGLE, Extended Health Care**
☐ **SINGLE, Dental**

If you are eligible for family coverage your dependents must have coverage* through your spouse

_____
Spouse's Employer

_____
Spouse's Group Insurance Carrier

☐ **FAMILY, Extended Health Care**
☐ **FAMILY, Dental**

Please indicate if you have coverage* through your spouse
E.H.C. ☐ No ☐ Yes
Dental ☐ No ☐ Yes

If 'Yes' indicate Spouse's Group Insurance Carrier

_____

Claims must be submitted to the primary carrier first. Any portion of the claim not reimbursed by the primary carrier should be sent to the secondary carrier for consideration. Children's claims are reimbursed by the plan of the parent whose date of birth falls first in the calendar year.

☐ **WAIVE, Extended Health Care**
☐ **WAIVE, Dental**

To waive coverage you and your dependents must have coverage* through your spouse.

_____
Spouse's Employer

_____
Spouse's Group Insurance Carrier

* If comparable coverage ceases, you must notify RWAM within 31 days or you will be subject to medical evidence (at your expense) and a one year dental restriction.

ELIGIBLE DEPENDENTS

Name (state surname if different than employee's)	Date of Birth (yy/mm/dd)		Name (state surname if different than employee's)	Relationship to Employee	Date of Birth (yy/mm/dd)
Spouse		Children*			

Students aged 21 or over and under 25 (or as specified in your plan) are only eligible if they submit confirmation of full-time registration.

*Children of common-law spouses must reside with the employee to be eligible.

BENEFICIARY DESIGNATION

I revoke all prior beneficiary designations under this certificate. I hereby designate the following person(s) to receive all group life insurance benefits payable on my death. If more than 1 person is named, proceeds are to be shared equally, unless otherwise stated below. A separate Beneficiary Designation/Change form is required to name contingent beneficiaries.

Beneficiary (ies) *→

Name(s) (first, middle initial, last)	Relationship to Insured	% Shares (must = 100%)
		%
		%
		%

Trustee * **If a beneficiary is under age 18:** Consider naming a Trustee as benefits cannot be paid to a minor. Benefits will be paid to the named Trustee (regardless of beneficiary age) unless you change the designation to remove the Trustee.

Trustee Name (first, middle initial, last)	As Trustee for (beneficiary name)	Relationship to Beneficiary

AUTHORIZATION

I understand the information I provide on this form will be used by RWAM Insurance Administrators Inc.(RWAM) and the insurer for the purposes of determining eligibility for group insurance coverage and benefits; and to administer benefits under this coverage. I hereby authorize my employer/plan administrator, the authorized group agent/broker, and the insurer to exchange any relevant and necessary information for such purposes. If I am applying for coverage for my eligible dependents, I confirm I am authorized to act on their behalf for such purposes. I declare that the statements made on this form are complete and true. I understand that if any statement is incomplete or false, any coverage granted may be voided. This authorization will remain valid for as long as I am claiming benefits or service, or until revoked by myself.

Employee's Signature X _____ Date _____ (yy/mm/dd)

OFFICE USE ONLY

Effective Date	Life Volume ☐ GF	WI Volume ☐ GF	LTD Volume ☐ GF	Extended Health Care ☐ Single ☐ Family ☐ Nil	Dental ☐ Single ☐ Family ☐ Nil

FOR ELECTRONIC DEPOSIT OF BENEFITS COMPLETE REVERSE

RWAM

APPLICATION FOR ELECTRONIC DEPOSIT OF GROUP BENEFIT PAYMENTS

INFORMATION

Electronic deposit of funds allows RWAM Insurance Administrators Inc. to deposit your Group Benefits payments directly to your bank, trust company or credit union account.

We hope you find this service convenient as your claims payment will automatically appear in your account each time a claim is submitted and approved. A corresponding Explanation of Benefit (E.O.B.) letter will be mailed to you explaining the benefit payment, or if you prefer, this explanation of benefit can be e-mailed to you. Please indicate how you would like to receive your E.O.B. and include e-mail address, if desired.

With this service you avoid mailing delays, lost or stolen cheques.

To have your claims benefit payment deposited electronically, simply complete this form and return it to us along with a personalized cheque marked "VOID".

If your banking information changes, we require at least 3 weeks notice to avoid any delay in your payment.

Please return this form and your void cheque to:

RWAM Insurance Administrators Inc.
Group Administration Department
49 Industrial Drive
Elmira, ON N3B 3B1

Or fax the form and voided cheque to (519) 669-1923

AUTHORIZATION

RWAM Insurance Administrators Inc. – Company Privacy Statement

RWAM Insurance Administrators Inc. is committed to protecting the privacy, confidentiality, accuracy and security of personal information it collects, uses, retains or discloses in the necessary conduct of our business.

Authorization

I hereby authorize RWAM Insurance Administrators Inc. to deposit Group Benefits (Extended Health, Dental and/or Disability) payments directly to my account and to exchange my relevant financial information with my financial institution for such purposes. This authorization shall remain valid until revoked by me in writing. Any copy of this authorization shall be as valid as the original.

Employee Name _____ Employer Name _____

Group # _____ Certificate # _____ Financial Institution _____

Home Address _____ Branch Address _____

_____ _____

I would like my E.O.B. sent to my:

E-mail address ☐ (indicate e-mail address) _____

Home address ☐

Disclaimer: The transfer of any personal information by e-mail is not 100% secure. Your consent to transfer information by e-mail is given with this knowledge and understanding, and RWAM Insurance Administrators Inc. does not accept any responsibility for any interceptions of e-mails by unauthorized parties.

Employee Signature X _____ Date (yy/mm/dd) _____

Please include a personal cheque marked "VOID".

BANKING VERIFICATION

If a void cheque is not included, please have the following completed by your financial institution.

Bank # _____ Branch # _____ Account # _____

Name(s) of Account Holder _____

Signature of Branch Officer X _____ Date (yy/mm/dd) _____

Title _____ Branch Phone #(including extension) _____

RWAM Insurance Administrators Inc.
49 Industrial Drive,
Elmira, ON N3B 3B1
Fax: 519-669-1923

Group Health Evidence Form
Employee Application

Group/Div # _____

Certificate # _____

Insurer(s) _____

TO BE COMPLETED BY EMPLOYEE — **Entire Application to be completed in ink. PLEASE PRINT**

Name of Employee				Phone Number:
				Work ( )
Address of Employee No. & Street	City	Prov.	Postal Code	Home ( )
Name of policyholder/employer	Occupation			Are you Actively at Work? ☐ Yes ☐ No If No, why?
Date of Birth Day Month Year	Height	Weight		☐ Male ☐ Female

1. Have any family members been diagnosed with diabetes, heart disease, high blood pressure, elevated blood fats, cancer, mental illness, HIV, or had a stroke?
☐ No ☐ Yes, If Yes, specify:

2. Have any of your parents, brothers or sisters had any hereditary disorder (e.g. Huntington's chorea, polycystic kidney disease, etc.)?
☐ No ☐ Yes, If Yes, specify:

3. Have you ever consulted a physician or alternative healthcare provider (including herbalist, acupuncturist, chiropractor, or practitioner of homeopathy or naturopathy, etc.) for, or ever had any condition of (please specify which):	Yes	No
a) Disorder of eyes, ears, nose, or throat?	☐	☐
b) Severe headaches, dizziness, fainting, loss of consciousness, epilepsy, seizures, speech disorders, paralysis, stroke, disorder of the brain or nervous system?	☐	☐
c) Nervous disorders, including depression, severe anxiety or suicidal thoughts?	☐	☐
d) High blood pressure, palpitation or pain about the heart or chest, difficult breathing, cardiac disorders, angina or coronary disease, rheumatic fever, heart murmur, heart attack or other disorder of heart or blood vessels?	☐	☐
e) Persistent cough or hoarseness, coughing of blood, asthma, emphysema, pleurisy, bronchitis, tuberculosis, respiratory disease or other disorder of the lungs?	☐	☐
f) Ulcer of stomach or duodenum, recurrent indigestion, jaundice, gall stones, colitis, bleeding or chronic diarrhea, disorders of stomach, gall bladder, liver, intestines, pancreas, rectum, or digestive system?	☐	☐
g) Hepatitis A, B, C, or "type unknown"?	☐	☐
h) Albumin, sugar, pus or blood in urine, diabetes, kidney stone or colic, or any other disorder of kidney or bladder?	☐	☐
i) Arthritis, gout, rheumatism, sciatica, deformity or disorder of joints or limbs, any disorder of the muscles or spine, including degenerative disc disease, pain in neck or back, trauma to spine, use of brace or cervical collar, fibromyalgia or chronic fatigue syndrome?	☐	☐
j) Leukemia, anemia, hemophilia, or any other disorder/abnormality of the blood?	☐	☐
k) Cancer, tumours, enlarged glands (nodes) or skin lesions, abnormal cysts or growths, disorder of pituitary, adrenals or other glands or unexplained infections?	☐	☐
l) Thyroid or other endocrine disorders?	☐	☐
m) Venereal disease or any other sexually transmitted disease or disorder of prostate or reproductive organs?	☐	☐
n) Any other conditions, illnesses, diseases, injuries or operations not mentioned above?	☐	☐

Details of "Yes" answers:

Identify question number, circle applicable items.
Include date, diagnosis, duration, type and amount of treatment (list name of drug, strength and dosage, if applicable), outcome/result, as well as name and address of doctor consulted.

(CONTINUED OVER....)

	Yes	No	Details of "Yes" answers:
4. In the past ten years have you:			Identify question number, circle applicable items. Include date, diagnosis, duration, type and amount of treatment (list name of drug, strength and dosage, if applicable), outcome/result, as well as name and address of doctor consulted.
a) Had or been told you had Acquired Immune Deficiency Syndrome (AIDS), or "AIDS" Related Complex (ARC), or "AIDS" related conditions?	☐	☐	
b) Received advice or treatment in connection with any of the categories mentioned in 4.a)?	☐	☐	
c) Tested positive for antibodies to AIDS (Human T-cell Lymphotropic, TYPE III); HTLV-III virus?	☐	☐	
5. Has an application for insurance on your life/health ever been declined, rated, or modified in any way?	☐	☐	When? Why? Company?
6. Do you currently have an individual life policy that has been issued within the last two years?	☐	☐	Issued by which insurance company?
7. Have you ever applied for or received a pension or Worker's Compensation or disability benefits because of illness or injury?	☐	☐	When? Why?
8. Have you lost any time from work during the last 12 months because of illness or injury?	☐	☐	When? Amount of time? Why?
9. Do you have any condition for which hospitalization or surgery has been advised or is contemplated?	☐	☐	Give details and dates:
10. Are you receiving any other treatment/medication from any physician or alternative healthcare provider as previously not defined?	☐	☐	State type and frequency:
11. Female Applicant:			
a) Have you ever had any disease of the breasts, ovaries, cervix or uterus?	☐	☐	
b) Have any pregnancies or labours been abnormal?	☐	☐	
c) Are you pregnant? If "Yes" give expected delivery date.	☐	☐	
12. Do you now or have you ever used alcohol? If "Yes", complete the following:	☐	☐	
a) Frequency of use (daily, weekly, monthly) _____			
b) Amount consumed on each occasion _____			
c) Date last used _____			
13. Over the past three years have you ever had your driver's license suspended or revoked for any medical reason, or for driving under the influence of drugs or alcohol?	☐	☐	Reason:
14. Have you ever received or been advised to obtain any treatment for alcohol/drug use (including AA membership)?	☐	☐	
15. Do you now or have you ever used non-prescription drugs, hallucinogenic, stimulant, narcotic, sedative or tranquilizing drugs (including marijuana or cocaine)? If "Yes", complete the following:	☐	☐	
a) Type of drug _____			
b) Frequency of use (daily, weekly, monthly) _____			
c) Date last used _____			
16. Have you ever used any form of tobacco, nicotine products or substitutes (including nicotine patch and gum)?	☐	☐	For how long and how often? How long have you been smoking?

17. Who is your regular family physician? (If none, name Walk In Clinic used) _____

Address _____

Approximate date last seen _____ Reason/Outcome _____

RWAM Privacy Statement

RWAM Insurance Administrators Inc. is committed to protecting the privacy, confidentiality, accuracy and security of personal information it collects, uses, retains or exchanges in the necessary conduct of our business.

Applicant Employee's Declaration and Authorization:

I hereby authorize any physician, hospital, clinic or any other medical or health care provider or facility, any insurance company, provincial health insurance plan, government department or agency, or any other person or organization having any medical or other relevant personal information or records regarding me to release to and exchange with RWAM Insurance Administrators Inc. ("RWAM") and/or the relevant insurer(s), their respective authorized plan administrators, representatives and/or agents, any and all information necessary for any or all of the following purposes: to underwrite my application for group insurance coverage, evaluate my eligibility for such coverage and adjudicate all insurance claims ("Purposes").

I authorize the release of information obtained during the underwriting process by RWAM and/or the relevant insurer(s) to my personal physician and to any reinsurers of my insurer(s), and when required to Public Health Authorities.

I further authorize RWAM and/or the relevant insurer(s), their respective authorized plan administrators, representatives and/or agents to request I undergo any such medical or paramedical examination(s) or evaluation(s) as may be required for the Purposes. I understand that my refusal or withdrawal of consent may result in the delay or denial of this application. I acknowledge that any information obtained from any paramedical or medical examination, any medical form(s), questionnaire(s) or any other written statements completed and furnished as evidence of insurability shall form part of this application and I declare that all such information and the information provided in this application to be true, complete and accurate. I acknowledge that any failure to disclose or any misrepresentation of any material fact may void my coverage. This authorization shall remain valid unless revoked in writing by me. Any copy of this authorization shall be as valid as the original.

Employee Signature X _____ **Date** _____

This form must be received at RWAM's office within 60 days of the date signed above. Otherwise a new form must be submitted.