



GROUP ENROLLMENT CARD

(SHORT TERM DISABILITY, LONG TERM DISABILITY,
LIFE, ACCIDENTAL DEATH & DISMEMBERMENT AND VOLUNTARY/OPTIONAL LIFE)

EMPLOYER SECTION (to be completed by Employer)					
NAME OF EMPLOYER		POLICY NUMBER(S)		BILLING DIVISION	CLASS NO.
OCCUPATION / TITLE		DATE EMPLOYED FULL-TIME		EARNINGS	NUMBER OF HOURS WORKED PER WEEK
		MM DD YYYY		\$ _____	<input type="checkbox"/> Hr. <input type="checkbox"/> Wk. <input type="checkbox"/> Mth. <input type="checkbox"/> Yr.

EMPLOYEE SECTION (to be completed by Employee)					
EMPLOYEE NAME			DATE OF BIRTH		PROVINCE OF RESIDENCE
LAST FIRST INITIAL			MM DD YYYY		LANGUAGE
					<input type="checkbox"/> ENGLISH <input type="checkbox"/> FRENCH
DO YOU HAVE DEPENDENTS? <small>NOTE: Children must be younger than 21 and/or age 21-25 who are full-time students to be eligible.</small>				SPOUSE - DATE OF BIRTH	
<input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD(REN)				MM DD YYYY	

BENEFICIARY DESIGNATION (to be completed by Employee)					
<i>To name more than one beneficiary or to name a contingent beneficiary, ask your plan administrator for assistance.</i>					
Applicable to Life or AD&D coverages					
Beneficiary's Last Name	First Name	Initial	%	Relationship	
_____	_____	_____	_____	_____	
_____	_____	_____	_____	_____	
_____	_____	_____	_____	_____	
If none of the above is living then pay _____					
					REVOCABLE <input type="checkbox"/>

FOR RESIDENTS OF QUEBEC ONLY:

A spousal beneficiary designation is irrevocable unless you make the designation revocable by checking here.

VOLUNTARY LIFE SECTION ONLY (to be completed by Employee) Attach an Evidence of Insurability form when applying for this benefit.					
AMOUNT OF COVERAGE	YOU:	YOUR SPOUSE:	EACH CHILD:	HAVE YOU SMOKED ANY CIGARETTES IN THE LAST 12 MONTHS?	
SELECTED FOR:	\$ _____	\$ _____	\$ _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	

I hereby apply for the Group Insurance coverage for which I am now or may later become eligible and authorize my Employer to deduct the required contribution, if any, from my pay. I agree that any insurance issued as a result of this application shall take effect on the date I am actively employed on a full-time basis, otherwise on the date I return to full-time active employment, subject to approval by the Company and any waiting period pertinent to my Employer's plan. The Company shall not be liable for any claim commencing prior to the effective date of insurance. Please read our privacy policy on the reverse side of this form.

Employee's Signature _____ Date (mm / dd / yyyy) _____

For Our Office Use Only	Occ Code	Date Received	Effective Date	Cert No(s)	Approved By
		Month Day Year	Month Day Year		

83576 (10/2006)

YOUR PRIVACY MATTERS TO US

At RBC Insurance®, we're committed to protecting your privacy. We respect your privacy and want you to understand how we safeguard your personal information.

How we collect your information

We collect and keep information about you, which is needed to provide the products and services that you or your employer request. We collect information from you, either directly or through our representatives. We may also need to collect information about you from sources such as other insurance companies, doctors and other health care providers, the government and governmental agencies, and your employer.

How we use your information

We use your information to provide the products and services you request, which includes using it to evaluate insurance risk, manage claims and administer the insurance. We may also share your information with others who work for RBC Insurance or other RBC Financial Group™ companies, or with third parties, when it is necessary for the services we provide to you. Third parties may include other insurance companies, the government and governmental agencies, and your employer. Your health information will not be shared with your employer without your consent.

We may use this information internally, to prepare statistical reports that help us understand the needs of our customers, and that help us understand and manage our business.

Social Insurance Numbers will be used for identification purposes if you have given us permission to do so, and will be used for taxation purposes when necessary.

Other ways we may use your information

When you request products and services directly from RBC Insurance, there are other ways we may use your information. For example, we may use or share some of your information to help you find out about other products and services from RBC Insurance and other RBC Financial Group companies. However, we will never use or share health information for these purposes. To better manage your relationship with other RBC Financial Group companies, and where the law allows us, we may consolidate the information we have about you with information held by the other member companies.

If, at any time, you decide that you do not want us to use your information as described here, under "Other ways we may use your information", please let us know by calling us at 1-800-298-5950.

Your right to access your information

You have a right to access the personal information that we have about you in your file. If we have information that is not correct, you can have it corrected.

To access your information or to ask us to correct information, you can contact us at:

RBC Insurance

1122 International Boulevard

PO Box 5044

Burlington, ON L7R 4C1

Telephone: 1-888-604-3434 Facsimile: 1-800-296-6987

If you would like more information about client privacy

RBC Financial Group publishes a brochure on client privacy. If you would like a copy of the brochure, please call 1-800-298-5950.