

# Application for Retiree Benefits



## Member Information

Member Name (first, initial, last) Birth Date (yy/mm/dd) Sex  M  F

Address City Province Postal Code

Home Telephone Number Work Telephone Number

Are you covered under the Manitoba Provincial Health Plan?  Yes  No Provincial Health Number (six digits)

## Coverage Information

I hereby apply for insurance under Wester Financial Group, subject to all terms, conditions and provisions of the policy, and authorize the necessary premium deductions from my earnings.

Coverage Designation (select only one)  Single  Family

Does your spouse have coverage elsewhere? Health:  Yes  No Dental:  Yes  No  
If Yes:  Single  Family If Yes:  Single  Family

If Yes, Please indicate Policy Number Insurance Company

You may opt out of benefits for yourself and your dependents only if you are covered for similar benefits under your spouses plan. To be eligible for Extended Health Care benefits, you and your dependents must be registered and covered through your applicable provincial health plan.

## Family Information

Name of Dependent(s)	Birth Date (yy/mm/dd)	Sex	Relationship to Employee	Disabled*	Full Time Student*
		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

\*Please submit a Western Financial Group Over-age Dependent Coverage form for any child over age 21 who is a FULL-TIME STUDENT or DISABLED. Note: Legal court documents are required if your dependent has been adopted by you. Eligible dependents must not be living out-of-country.

All Statements, representations and answers made in this application are consideration for and a basis of the insurance herein requested and whether written or printed are declared to be true, full and complete.

At Western Financial Group, we know that confidentiality of personal information is important. Any information you provide to us will be kept in a group life and health benefits file. Access to your information will be limited to:

- our employees and representatives in the performance of their jobs;
- persons to whom you have granted access in writing; and
- persons authorized by law.

You have the right to request access to the personal information in your file and, if necessary, correct any inaccurate information.

Western Financial Group is focused on respecting your privacy and maintaining confidentiality of information. We have safeguards in place to protect your personal, business, and financial information which adheres to the Ten Privacy Principles as covered by the Personal Information Protection and Electronic Document Act ([www.privcom.gc.ca](http://www.privcom.gc.ca)). To learn more about Western Financial Group's commitment to privacy and security refer to our web site: [www.westernfg.ca](http://www.westernfg.ca)

Employee Signature

Date

Please complete reverse side.

# Pre-Authorization Chequing

The bank specified below is authorized and requested to debit my account in accordance with this agreement for all premiums payable to Western Financial Group for my/our Insurance costs.

## Bank or Financial Institution Information

Name of Bank or Financial Institution

Branch Address

City

Province

Postal Code

- Your treatment of each cheque or debit shall be the same as if I/we had personally issued a cheque.
- Delivery of this authorization to you constitutes delivery by me/us.
- This authorization can be cancelled by me/us at any time upon written notice.
- I/We will ensure that funds are available to cover the amount of withdrawal, as notified to me/us by Western Financial Group.
- \$10.00 service fee will be charged to each (P.A.C) returned for non-sufficient funds (NSF).

Please attach a void cheque and complete the following information which is found on the bottom of your cheque as per the sample below. This information is required to ensure funds are withdrawn from the correct account.

(1) Transit Number (5 Digits)

(2) Bank Number (3 Digits)

(3) Account Number (Various)

## Sample

Name			_____ 20 _____
Address			
Name			\$ _____
			_____ / 100 Dollars
Bank/Credit Union			
(1)	(2)	(3)	
09267:	002:	638:194:02	
(Transit)	(Bank)	(Account Number)	_____

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Signature

Date Signed (yy/mm/dd)