HealthSource Plus
Group Benefits · Administration · Wellness · Retirement

HealthSource Plus is a People Corporation company

Request For Optional Life Insurance

Complete this form using ink. *Forms with pencil will not be accepted.*

1. Plan Sponsor/Employer Information

Employer's Name:	Group Policy #:
Division #:	Unit #:

2. Employee Information Tell Us About Yourself

Last Name	First Name	Employee Certificate #:
Mailing Address:		
Telephone Numbers (including area code):		Language Preference
Home	Work	☐ English ☐ French
Gender ☐ Male ☐ Female	Date of Birth: (MM/DD/YYYY)	Current Salary: $

3. Request for Optional Life Coverage

Employee Optional Life (please check one)		Spousal Optional Life (please check one)	
☐ **New Application**		☐ **New Application**	
Amount applying for:	$	Amount applying for:	**$**
☐ **Increase in Coverage**		☐ **Increase in Coverage**	
Existing Coverage Amount	**$**	Existing Coverage Amount	**$**
New Total Coverage Amount	**$**	New Total Coverage Amount	**$**

Non-Smoker Status Declaration: I declare that I do not smoke and have not smoked any tobacco products such as cigarettes or pipes or any drugs during the past 12 months. This statement is an affirmative guarantee on my part. It is understood that the insurer may periodically require confirmation on non-smoker status. The participant must be in a position to meet the requirements then in force and return the confirmation within 30 days of the request, failing which the participant shall lose the non-smoker status and the associated premium reduction shall cease to apply as of the date of the insurer's request. I also acknowledge that a false or incomplete statement may cause the coverage to be null and void.

Employee Signature	**Spouse Signature**

4. Spousal Information

Last Name	First Name	Gender ☐ Male ☐ Female		
Date of Birth: (MM/DD/YYYY)	Cohabitation Date (common law spouses only)	Month	Day	Year

5. Beneficiary

The beneficiary for Employee Optional Life will be the same as designated for your Employee Basic Life Insurance. The beneficiary for the Spousal Optional Life shall be the employee, if living, otherwise the estate.

6. Employee Authorization

I declare that the statements I have made on this form are true and complete. I understand that if any statement is incomplete or false and/or if I do not abide by the terms and conditions as set forth in the insurance policy and/or this application for insurance, my benefits may be terminated.
I certify that I am authorized to disclose and receive information about my spouse and/or my dependents.
I understand that HealthSource Plus Inc. shall have the right to recover from myself and/or my dependents any payments made in error or as a result of fraud, as well as any costs related directly to the recovery of such funds.
I authorize my employer to deduct from my salary the premiums required for approved coverage.
I authorize HealthSource Plus, its agents, insurers and service providers to use and exchange information collected in this form to underwrite, administer, determine eligibility and adjudicate claims.

Name (Please Print)	**Signature**	**Date Signed MM/DD/YYYY**

Fax this completed form to your HealthSource Plus servicing office:

Toronto 416.445.2222 **Montreal** 514.331.6486 **Niagara** 905.357.0807 **Winnipeg** 204.940.3901