ALLSTATE INSURANCE COMPANY OF CANADA (AICC)

27 Allstate Parkway, Suite 100, Markham, Ontario, L3R 5P8

Allstate BENEFITS

Mail or Scan to:
Allstate Benefits
49 Industrial Drive, Elmira, Ontario, N3B 3B1
csr-allstate@rwam.com

ENROLMENT FORM

GENERAL INFORMATION

☐ New Certificate ☐ Change/Increase Certificate # _____

Employee's Name (Surname, First, M.I.)		Employee ID Number	☐ M ☐ F
Number and Street	City	Province	Postal Code
Date of Birth	Phone Number	Email	
Employer/Association/Union	Date Hired	Occupation	Plant Or Division

DESIGNATION OF BENEFICIARY (If designating more than one beneficiary, please list and make sure total equals 100%.)

Primary Beneficiary's Full Name	Phone Number	Relationship	Date of Birth	%
Primary Beneficiary's Full Name	Phone Number	Relationship	Date of Birth	%
Contingent Beneficiary's Full Name	Phone Number	Relationship	Date of Birth	%
Contingent Beneficiary's Full Name	Phone Number	Relationship	Date of Birth	%

TRUSTEE APPOINTMENT: If you designate a minor child (under age 18 or 19 depending on Province of Residence of the minor) as the beneficiary of your insurance proceeds, the proceeds will be paid into court unless a trustee is appointed to receive such benefits on behalf of such child (you may wish to consult a lawyer before appointing a Trustee).

Full Name of Trustee	Address and Phone Number

COMPLETE THIS SECTION FOR PERSONS TO BE INSURED

Surname	First Name	Relationship	Gender	Date of Birth

In the past 12 months, have you (or your spouse, if covered) used any form of tobacco, nicotine products, or substitutes (including the nicotine patch or gum)?

Employee ☐ Yes ☐ No Spouse ☐ Yes ☐ No

Are you changing existing coverage due to a qualifying event such as marriage, birth, or adoption? ☐ Yes ☐ No

If "Yes", please complete the following: Qualifying Event _____

Date of Qualifying Event _____ Current Certificate Number(s) _____

SELECTION OF COVERAGE (Answer Yes or No and complete for the coverage selected)

Critical Illness ☐ Yes ☐ No	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	**Benefit Amount** $ _____	**Home Office Use Only**

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Eligibility Question		Employee
Critical Illness	Are you actively at work now, for wage or profit, and have you worked at least 20 hours each week performing all duties of your regular occupation at your regular place of employment for at least 3 months except for minor illness or injury of 1 week or less, or normal pregnancy?	☐ Yes ☐ No

ELECTRONIC ACCEPTANCE (Please check YES or NO)

By checking the "Yes" box, I elect electronic delivery of my certificate(s) of insurance, including all documents accompanying my certificate(s) of insurance. If electronically delivered, I understand that I will receive instructions at the email address I have provided on how to receive my certificate and accompanying documents.

☐ Yes ☐ No

By checking the "Yes" box, I elect electronic delivery of all contractual, regulatory and administrative correspondence (correspondence) regarding my certificate(s) of insurance, to include claim correspondence, explanations of benefits, periodic notices (such as privacy notices) and other correspondence. If electronically delivered, I understand that I will receive instructions at the last email address I have provided on how to receive correspondence.

☐ Yes ☐ No

I understand and agree that to receive electronic delivery, I must have a computer with internet access, a web browser that is Microsoft Internet Explorer version 5.0 or greater, an e-mail account, and the ability to download PDF files using Adobe Acrobat Reader version 5.0 or higher and a printer or other device to download and print or save any documents I wish to retain.

I understand and I agree that my consent is valid while I remain covered. At any time, I may withdraw my consent for any reason and receive future correspondence in paper to include a paper copy of my certificate(s) of insurance, free of charge, by calling toll-free: 1-844-455-6255; or by writing to: RWAM Insurance Administrators Inc., 49 Industrial Drive, Elmira, Ontario, N3B 3B1.

ACCEPTANCE/AUTHORIZATION: I hereby request all coverage(s) checked “yes” above for which I am or may become eligible under the group coverages issued by Allstate Insurance Company of Canada. **I AUTHORIZE** my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverages requested. **EFFECTIVE DATE:** I understand that the “effective date” of my elected coverages will be the effective date recorded on my Certificate, not the date this Enrolment form is signed. **WAIVER/DECLINATION:** I understand that if I refuse any coverage for which I am eligible (by checking “no” above), satisfactory proof of insurability may be required, at my own expense, should I desire to apply for it at a later date. Any such application may be declined on the basis of such proof.

Date Signed _____ Employee’s Signature _____