



Application for Group Benefits

EMPLOYEE BENEFITS LTD.

A & W REGIONAL FRANCHISE ASSOCIATION

New Application Reinstatement

Employee Waiting Period:
 0 months 6 months 12 months

Employee's Surname	First Name	Middle Initial	Social Insurance Number				Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate YY MM DD	Policy Contract Number and Division
Registered Name of Employer		Name of Restaurant		Number of Hrs. Worked per Week	Date Employed Full Time YY MM DD			Effective Date	
Occupation of Employee		Employee Earnings \$		Bi Hr Wk Wk Mo Yr		Employer Contribution %		Employee Address	
Class 1 = Salaried Employee: Class 2 = Hourly Employee: Class 3 = Entry Level Hourly Employee: Class 4 = Salaried Employee: Class 5 = Hourly Employee:		Benefits: Life, AD&D, LTD, Health & Dental Benefits: Life, AD&D, LTD, Health & Dental Benefits: Life, AD&D, Health & Dental Benefits: Health & Dental Only Benefits: Health & Dental Only		Class Code					
Beneficiary Designation -- I hereby designate as revocable beneficiary in the event of my death: Name _____ Relationship _____ Trustee designation for beneficiary under legal age: <i>I hereby appoint as trustee to receive any amount due my beneficiary under legal age and authorize such trustee to spend all or any portion of such amount and the income from it for the maintenance and education of such minor.</i> Name of Trustee _____								City _____ Prov. _____ Postal Code _____	
If previously covered for these benefits with another employer or insurance company complete this line Group Number of Previous Coverage _____ Social Insurance Number _____ Termination Date YY MM DD _____ Name of Insurance Company and Benefits Covered _____									
Complete this section if you have eligible dependents Note -- If you do not want your dependents covered for eligible benefits, complete a "Waiver of Group Benefits" Card Indicate if student or handicapped. Include name of school/university or nature of handicap								I authorize the use of my Social Insurance Number for tax reporting and identification and benefit administration. I authorize my employer to deduct required contributions from my earnings (if applicable), and I agree to the conditions of the contract between my employer and the Insurance Company(ies). I also agree that the information included in this application is true and complete. Signature of Employee _____ Date Signed _____ Waiver Card Attached <input type="checkbox"/> Yes <input type="checkbox"/> No	
List Dependents, oldest first									
Dep. #	First Name	Initial	Surname	Gender M/F	Birthdate YY MM DD		S/H		
01	Spouse								
02	1st Child								
03	2nd Child								
04	3rd Child								
05	4th Child								
06	5th Child								
07	6th Child								

Please TYPE or PRINT clearly in ink

Please complete and return by Fax or Mail to:

HMR EMPLOYEE BENEFITS LTD.
 220-2186 Oak Bay Ave.
 Victoria, BC
 V8R 1G3
 Tel: (250) 592-4614
 Toll Free: 1-888-592-4614
 Fax: (250) 592-4953