Complete both pages of this form.
Plan administrator to keep original and send copy to:
3095 Woodbine Drive, North Vancouver, BC V7R 2S3
Phone: 604-980-6227 • Toll-Free: 1-800-432-9707 • Fax: 604-983-2935
Website: www.jbenefits.com

Application for Coverage

EMPLOYER/PLAN ADMINISTRATOR INFORMATION - Plan administrator to complete before sending form to Johnstone's

Employer Name	Client #	Division #	Department #	Class #	Employee #
Hitachi Vantara	91056				

☐ New Applicant ☐ Reinstatement	Earnings $	☐ Hourly ☐ Semi-monthly ☐ Bi-weekly ☐ Monthly ☐ Weekly ☐ Annually	Hours Worked Per Week	Commission $

Employee's Occupation	Permanent hire or re-hire date MM /DD /YYYY
Plan Administrator Name	Plan Administrator Phone #
Plan Administrator E-mail askhr@hitachivantara.com	Plan Administrator Signature Date mm/dd/yyyy

EMPLOYEE/PLAN MEMBER INFORMATION - Employee to complete green section (if applicable)

Last Name	First Name	Middle Initial	Sex ☐ Male ☐ Female

Date of Birth mm/dd/yyyy	Street Address

City	Province	Postal Code

Work Phone #	Personal Phone #	E-mail

Marital Status ☐ Single ☐ Married* ☐ Common-law** ☐ Divorced ☐ Separated ☐	Smoking Habits ☐ Smoker ☐ Non-smoker

*** including civil union in Quebec**

**Common-law Declaration

The policy provides that a person with whom the insured employee has been co-habitating for a period as stated in the policy and who is being represented publicly as the spouse, will be eligible for benefits, provided the employee files with the insurer, the name of the person to be considered the spouse for the purpose of this policy.

For the purpose of this policy, my spouse is: Last Name	First Name	This person has been known as my spouse since

DEPENDENT INFORMATION

	Last Name	First Name	Middle Initial	Sex	Date of Birth MM/DD/YYYY	Full-time Student (age 21 or older)	Disabled	Name of Educational Institution or Details of Disability*
Spouse				☐ M ☐ F		N/A	N/A	N/A
Child				☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No	
Child				☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No	
Child				☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No	
Child				☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No	

*** Complete this section if the child is over the age of 21 and attending school full-time or is disabled.**

SPOUSE'S COVERAGE

Does your spouse have coverage under his/her own: **Extended Health Care Plan?** ❑ Yes ❑ No **Dental Care Plan?** ❑ Yes ❑ No

Spouse's Employer	Insurer	Policy #	Insurer	Policy #

Does your spouse's plan cover:

Extended Health Care
- ☐ Your spouse only
- ☐ Your spouse and you only
- ☐ Your spouse and your children only
- ☐ Your spouse, you and your children

Dental Care
- ☐ Your spouse only
- ☐ Your spouse and you only
- ☐ Your spouse and your children only
- ☐ Your spouse, you and your children

WAIVER OF BENEFITS*

If you or your dependents are presently covered for extended health care and/or dental care benefits under your spouse's group insurance plan, you may refuse coverage for those benefits by selecting the applicable box:

I refuse coverage for myself and my dependents under ❑ **Extended Heath Care** ❑ **Dental Care**
I refuse coverage for my dependents under ❑ **Extended Health Care** ❑ **Dental Care**

*** If coverage under your spouse's plan terminates, you have 31 days after the date of the termination to apply for coverage under this plan without evidence of good health. After 31 days you may be required to submit satisfactory evidence of insurability for you and your dependents, at your own expense, and coverage may be denied or restrictions may apply.**

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If you make an error, sign or initial beside the correction.

EMPLOYEE/PLAN MEMBER INFORMATION (continued)

BENEFICIARY DESIGNATION

If a beneficiary is not assigned, the benefit will be payable to the ESTATE. If a beneficiary is under the age of majority, complete TRUSTEE DESIGNATION.

Last Name	First Name	Middle Initial	Relationship to Plan Member	Age	Percentage*
					%
					%
					%

* Percentages must total 100%

For Quebec residents only: In Quebec, the designation of your legal (by marriage or civil union) spouse as the beneficiary is irrevocable unless otherwise specified.
If beneficiary designation is irrevocable, the beneficiary's consent is required to change it.

I hereby make the above beneficiary designation revocable: ☐ **Initial**

CONTINGENT BENEFICIARY DESIGNATION

If you wish to appoint a contingent beneficiary, complete this section. If a beneficiary is under the age of majority, complete TRUSTEE DESIGNATION.

If there is no surviving beneficiary at the time of my death, the following contingent beneficiary shall receive the benefit. If there is no surviving contingent beneficiary at the time of my death, the benefit will be payable to the ESTATE.

Last Name	First Name	Middle Initial	Relationship to Plan Member	Age	Percentage*
					%
					%
					%

* Percentages must total 100%

For Quebec residents only: In Quebec, the designation of your legal (by marriage or civil union) spouse as the beneficiary is irrevocable unless otherwise specified.
If beneficiary designation is irrevocable, the beneficiary's consent is required to change it.

I hereby make the above beneficiary designation revocable: ☐ **Initial**

TRUSTEE DESIGNATION (Not applicable in Quebec*) Complete if the beneficiary is under the age of majority (as defined by provincial legislation).

I hereby appoint as Trustee to receive any amount due to any beneficiary under the age of majority:

Last Name	First Name	Middle Initial	Relationship to Plan Member

***In Quebec, there may be issues with respect to the appointment of a trustee. You should consult a legal advisor regarding this matter.**

AUTHORIZATION AND SIGNATURE

I HEREBY APPLY for the benefits which I am or may become eligible for, subject to any waiver indicated, under my Employer's/Policyholder's group insurance plan and CONFIRM that the information contained in this form is true and complete to the best of my knowledge.

If applying for benefits for my dependents, I CONFIRM THAT I AM AUTHORIZED to disclose information concerning them for the purpose of determining their eligibility for coverage.

On behalf of myself and my dependents, I CONSENT TO THE RELEASE of the information contained in this form to my Employer/Policyholder, Johnstone's Benefits and its employees, and the agents, insurers and service providers for the purpose of underwriting, administration, claims processing and the enrollment of myself and my dependents in my Employer's/Policyholder's group insurance plan.

I understand that the insurers maintain a file related to my benefits and that I have the right to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected.

If my Social Insurance Number is used as my identification number, I AUTHORIZE its use for the administration of my group benefits.

If any contributions are required to be made by me with respect to my group benefits, I AUTHORIZE my employer to make any required deductions from my earnings and remit same to Johnstone's Benefits.

I AGREE that a photocopy of this Confirmation/Authorization shall be as valid as the original.

Employee/Plan Member Name	X Employee/Plan Member Signature	MM /DD /YYYY Date

At Johnstone's we recognize and respect every individual's right to privacy. When you apply for coverage, we establish a confidential file that is kept in our offices. We limit access to information in your file to Johnstone's staff, to insurers who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use the information to determine your eligibility for coverage and to administer the group benefit plan.

THIS FORM MUST BE SIGNED AND DATED