OPTIONAL LIFE INSURANCE — APPLICATION FORM

New Employees - Optional Life of $25,000

This Optional Life Insurance Application Form must be completed within 31 days of the employee's eligible effective date of group insurance.
This Optional Life Insurance application form should be provided to the employee at the same time as their Plan Member Enrolment form for group insurance benefits.
Please keep the original in the employee's file and return a copy to TELUS Health for processing.

1 a) — Group and Plan Member Information - Optional Life Insurance for NEW HIRE EMPLOYEES To be completed by Employer				
Group Name	**NSFM Group (indicate Town/Municipality Name)**			**Policy Number**
Nova Scotia Federation of Municipalities				140845
Date of Hire/Re-Hire (yyyy/mm/dd)	**Plan Member's Class**	**Waiting Period**	**Group Insurance Effective Date on Plan (yyyy/mm/dd)**	**Plan Member ID #**

1 b) -- Plan Member Information - Optional Life Insurance for NEW HIRE EMPLOYEES To be completed by Employee			
Plan Member Name (Last/First/Middle)	**Sex**	**Smoking Status***	**Birth Date (yyyy/mm/dd)**
	☐ M ☐ F	☐ Smoker ☐ Non-Smoker	

* To be considered a non-smoker you must not have smoked within the last 12 months.

2 — To be completed if applying for Optional Life Insurance for your spouse			
Spouse's Name (Last/First/Middle)	**Sex**	**Smoking Status***	**Birth Date (yyyy/mm/dd)**
	☐ M ☐ F	☐ Smoker ☐ Non-Smoker	

* To be considered a non-smoker spouse must not have smoked within the last 12 months.

3 — I am a new employee eligible for group insurance and applying for:	
Selection of Optional Life Insurance	**Select**
$25,000 Optional Life Insurance for MYSELF	☐
$25,000 Optional Life Insurance for my SPOUSE	☐

Please also complete reverse side (page 2 of 2) of this application form

4 — Beneficiary**				
Name of Beneficiary for Plan Member's Optional Insurance (Last Name)	(First Name)	(Middle Name)	Percentage (must total 100%)	Relationship to Plan Member

In the event the Primary Beneficiary(ies) predeceases the plan member, the following Contingent Beneficiary(ies) shall be entitled to the benefits:

Name of Beneficiary for Plan Member's Optional Insurance (Last Name)	(First Name)	(Middle Name)	Percentage (must total 100%)	Relationship to Plan Member

Name of Trustee for Beneficiaries Under Age 18

5 — Plan Member Declaration

I consent to the collection, use, and exchange of my personal information by my plan sponsor, the administrators of my retirement, savings, and other group benefits programs, the agents retained by my plan sponsor or the administrator, an insurance company, and/or other person who requires information for the purpose of retirement, savings, or other group benefits plan administration. I authorize these parties to obtain, and exchange between them, any information about me, my spouse, or my dependent children that they require for the purposes of determining my benefit entitlements, and for record-keeping, file identification, reporting, procurement of health information, claims resolution, program management, and other services provided to me and my plan sponsor from time to time. I confirm that I have obtained the consent required of my spouse and any dependent children over the age of majority to permit me to give the above consent as it relates to their personal information. I hereby confirm the above beneficiary designation, which replaces any previous revocable beneficiary. I reserve the right to change my revocable beneficiary designation at any time. I hereby apply for group insurance benefits under my plan sponsor's plan and authorize any required deductions.

I understand that optional life insurance is an optional benefit and that I, as the employee, is required to pay for these optional life insurance premiums.

I certify that the information given above is true and complete. A photocopy or electronic version of this authorization is as valid as the original.

Plan Member signature **Date signed**