Benefit Application/ Change Form
The University of Western Ontario – Human Resources
Support Services Building, Rm 4159, London, ON, N6A 3K7
❍ Application (New Employees Only) ❍ Change

Western

Employee Number: _____ Effective Date: _____ Employee Group: _____
Employee Surname/Given Name: _____
Department/Faculty Address: _____ Extension: _____

Basic Life: Surname Given Name Relationship

Beneficiary Designation → _____

_____

Optional Life: ❍ I wish to participate ❍ I do not wish to participate

Have you smoked (cigarettes, cigars, pipe, etc) or used tobacco in any form within the last 12 months?
□Yes □No

❍ Non-Smoker ❍ Smoker

❍ ½ times annual salary ❍ 1 times annual salary ❍ 1½ times annual salary ❍ 2 times annual salary

FOR PMA AND IUOE MEMBERS ONLY: ❍ 3 times annual salary ❍ 4 times annual salary ❍ 5 times annual salary

Surname Given Name Relationship

Beneficiary Designation → _____

_____

Dependent Life: ❍ I wish to participate ❍ I do not wish to participate

Spouse and/or child(ren) eligible to be covered under the Dependent Life plan:

		Surname, Given Name	Date of Birth (YYMMDD)	Relationship	Student	Disabled
Spouse	→ ❍ Add ❍ Delete					
Dependent Child(ren)	→ ❍ Add ❍ Delete				❍	❍
	❍ Add ❍ Delete				❍	❍
	❍ Add ❍ Delete				❍	❍

Voluntary Personal Accident: ❍ I wish to participate ❍ Employee Only ❍ Family ❍ I do not wish to participate **Amt of Coverage: $ _____**

Surname Given Name Relationship

Beneficiary Designation → _____

_____

Spouse and/or child(ren) eligible to be covered under the Voluntary Personal Accident Insurance plan (Family):

		Surname, Given Name	Date of Birth (YYMMDD)	Relationship	Student	Disabled
Spouse	→ ❍ Add ❍ Delete					
Dependent Child(ren)	→ ❍ Add ❍ Delete				❍	❍
	❍ Add ❍ Delete				❍	❍
	❍ Add ❍ Delete				❍	❍

Optional Spousal Life (FOR PMA MEMBERS ONLY): ❍ I wish to apply* ❍ I do not wish to participate

**Coverage is subject to approval of our Insurance Carrier, Manulife Financial. Human Resources will issue you the necessary paperwork to make an application for Optional Spousal Life Insurance. Manulife Financial will notify both you and Human Resources of their decision.*

Sick Leave and Long Term Disability:

You are automatically covered as specified under the provisions of your Collective Agreement.

Extended Health: ❍ Employee ❍ Family ❍ Claim exemption as covered under my spouse's plan
Dental: ❍ Employee ❍ Family ❍ Claim exemption as covered under my spouse's plan

Spouse and/or child(ren) eligible to be covered under the Extended Health & Dental plans:
For any overage dependent child(ren), please indicate whether student or disabled.

		Surname, Given Name	Date of Birth (YYMMDD)	Relationship	Student	Disabled
Spouse	→ ❍ Add ❍ Delete					
Dependent Child(ren)	→ ❍ Add ❍ Delete				❍	❍
	❍ Add ❍ Delete				❍	❍
	❍ Add ❍ Delete				❍	❍

Trustee Designation for Life plans if named beneficiary is under the age of 18:

	Surname	Given Name	Relationship
Basic Life →			
Optional Life →			
Voluntary Personal Accident →			

Contingent Beneficiary (ies) Designation for Life plans in the event that the above-named beneficiary(ies) predecease me or whose death occurs simultaneous to mine, I hereby designate the following contingent beneficiary(ies):

	Surname	Given Name	Relationship
Basic Life →			
Optional Life →			
Voluntary Personal Accident →			

Authorization:

I hereby apply for the above benefit plans and authorize the deduction from my pay for the amounts required towards the costs of the benefits for which I am now, or may later become, eligible.

_____ _____
Signature of Employee **Date**

_____
Human Resources Representative

For further information on your Group Benefit plans and premium rates, please refer to our website at http://www.uwo.ca/hr/. The personal information provided on this form is protected under the provisions of the Privacy Act and will be used only for the purposes for which it was collected.

Human Resources Administration: Home/Compensate Employees/Administer Automated Benefits/Use/Bas Activity or Data Entry (By Participant)

RF ER #_____Flagged ❑ _____Date _____Entered ❑ _____Date _____ID# ____Verified ❑ _____Date_____
Initials YYMMDD Initials YYMMDD Initials YYMMDD

❑ **O/C General Deduction Data**
❑ **Benefit/Pension Base Override**