POSTDOCTORAL ASSOCIATES BENEFIT APPLICATION/ CHANGE FORM

Send completed forms to hrhelp@uwo.ca or
Human Resources, Support Services Building, Room 4159, London, ON, N6A 3K7

SECTION 1: PERSONAL INFORMATION

Employee Last Name:	Employee ID #:
Employee First Name:	UWO Extension:

SECTION 2: EXTENDED HEALTH AND DENTAL PLANS—CHOOSE ONE

❍ Employee—Employer Paid
❍ Family—Required monthly contribution from member. Current monthly cost is $170.75

Spouse and/or child(ren) eligible to be covered under the Family Extended Health & Dental plans

Add	First Name	Last Name	Gender	Relationship	Date of Birth *YYYY/MM/DD*	Student/Disabled
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For any overage dependent child(ren), please indicate whether student or disabled. A completed Overage Dependent Child Declaration Form is required for coverage to be activated. Coverage for a disabled child is subject to the approval of our carrier. Both forms are available upon request.

SECTION 3: OPTIONAL LIFE—CHOOSE ONE

I elect the following coverage:
❍ Optional Life Insurance Coverage in the amount of $_____
❍ Waive Participation

You may purchase any amount of insurance in multiples of $50,000 subject to a minimum of $50,000 and a maximum of $500,000.

Enrolment forms received prior to February 19, 2021 will not require proof of good health for coverage up to $150,000. Amounts greater than $150,000 will require proof of good health. Human Resources will issue the necessary paperwork for coverage requests greater than $150,000. Previous elections greater than $150,000 will not require proof of good health.

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

Monthly Cost for Optional Life Insurance (based upon each $50,000 of coverage & non-smoker rates)

	24-34	35-39	40-44	45-49	50-54	55-59	60-65
Male	$1.30	$1.50	$2.30	$3.45	$6.55	$11.00	$16.20
Female	$0.95	$1.30	$1.50	$2.45	$4.15	$6.55	$10.70

Optional Life Insurance Primary Beneficiary Designation

First Name	Last Name	Date of Birth *YYYY/MM/DD*	Relationship	Percentage Designated
			Total must equal 100%	0

I hereby revoke any previous beneficiary designations in relation to my forgoing coverage(s) and designate the person(s) named above.

Optional Life Insurance Contingent Beneficiary Designation

First Name	Last Name	Date of Birth *YYYY/MM/DD*	Relationship	Percentage Designated
			Total must equal 100%	0

Contingent Beneficiary(ies) Designation in the event that the named Primary beneficiary(ies) predecease me or whose death occurs simultaneous to mine, I hereby designate the above contingent beneficiary(ies).

SECTION 4: DEPENDENT LIFE INSURANCE—CHOOSE ONE

❍ Elect coverage
❍ Waive Participation

Current Premium Cost: $8.79/month

Life Insurance coverage of $40,000 on your spouse and $10,000 on each eligible child.

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

Add	Remove	First Name	Last Name	Gender	Relationship	Date of Birth *YYYY/MM/DD*	Student/ Disabled
☐	☐						
☐	☐						
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For any overage dependent child(ren), please indicate whether student or disabled. Proof of overage dependent status is needed prior to dependent having active coverage.

SECTION 5: VOLUNTARY PERSONAL ACCIDENT INSURANCE—CHOOSE ONE

❍ Employee Only coverage in the amount of $_____

❍ Family coverage in the amount of $_____

❍ Waive Participation

You may purchase any amount of insurance in multiples of $10,000 subject to a minimum of $20,000 and a maximum of $500,000.

Current Premium Cost:
Employee only: $1.50/month per $100,000 of coverage
Family: $2.40/month per $100,000 of coverage

Spouse and/or child(ren) eligible to be covered under the Voluntary Personal Accident Insurance Plan							
Add	Remove	First Name	Last Name	Gender	Relationship	Date of Birth *YYYY/MM/DD*	Student/ Disabled
☐	☐						
☐	☐						
☐	☐						

For any overage dependent child(ren), please indicate whether student or disabled. Proof of overage dependent status is needed prior to dependent having active coverage.

Voluntary Personal Accident Insurance-Family Coverage Primary Beneficiary Designation				
First Name	Last Name	Date of Birth *YYYY/MM/DD*	Relationship	Percentage Designated
			Total must equal 100%	0

Voluntary Personal Accident Insurance-Family Coverage Contingent Beneficiary Designation				
First Name	Last Name	Date of Birth *YYYY/MM/DD*	Relationship	Percentage Designated
			Total must equal 100%	0

Contingent Beneficiary(ies) Designation in the event that the named Primary beneficiary(ies) predecease me or whose death occurs simultaneous to mine, I hereby designate the above contingent beneficiary(ies).

SECTION 6: TRUSTEE DESIGNATION FOR LIFE PLANS IF NAMED BENEFICIARY IS UNDER THE AGE OF 18

Life Insurance Plan	First Name	Last Name	Relationship
Optional Life Insurance			
Voluntary Personal Accident Insurance			

SECTION 7: 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. I understand that I may be asked to provide proof of eligibility for all dependents listed at a later date. I hereby revoke any previous beneficiary designations in relation to my forgoing coverage(s) and designate the person(s) named below.

_____ _____

Signature of Employee Date

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.