



CHECKLIST

- Master Application - Ensure that application is complete, signed by the applicant and their signature is witnessed
Pre-Authorized Debit - Pre-Authorized Debit (PAD) is mandatory for this plan. Applicant must complete & sign the attached PAD Agreement.
Enrolment Form - Complete form in full and ensure that comparable coverage and opt-out sections are correct and signed
Binder/Deposit Cheque - Binder/deposit cheque payable to RWAM Insurance Administrators Inc. should equal one month of estimated premium using quoted rates.
Evidence of Insurability - Applicant must complete and submit a signed group Health Evidence form for approval

APPLICANT

Form fields for Applicant information: Full Legal Name, Contact Person, No. and Street, Telephone, City, Province, Postal Code, Fax and/or E-mail

CURRENT BENEFITS

Current coverage elsewhere? [ ] No [ ] Yes
If 'Yes' - Name of plan and benefits covered, Date existing coverage is to be terminated

POLICY EFFECTIVE DATE

Day Month Year
To avoid a period without coverage, do not terminate any existing coverage until notice has been given that RWAM Insurance Administrators Inc. has approved the coverage being applied for.

DESCRIPTION OF BENEFITS All benefits terminate at age 70

EXTENDED HEALTH CARE

Table with 3 columns: Benefit, Co-Ins., Maximum. Rows include Pay Direct Prescription Drugs, Anti-Smoking Drugs, Fertility Drugs, Private Duty Nursing, Paramedical Practitioners, Orthopaedic Shoes, Orthotics, Hearing Aids, Eye Examinations, Accidental Dental, Medical Supplies, Semi-Private Hospital, Out-of-Canada.

DENTAL CARE (Optional)

Group Dental Plan Participation [ ] Yes [ ] No
This plan will pay 80% of basic covered expenses. Benefit payment is based on the current Provincial Fee Schedule to a maximum of \$1,000 per calendar year, per individual.
List of dental services: Oral exams, X-rays, Fillings, Anesthesia, Endodontics, Periodontics, Repairs, relining & rebasing of dentures



PRE-AUTHORIZED DEBIT (P.A.D.) PLAN

- The P.A.D. withdrawal will be processed the 1st day of each month.
ATTACH A VOID CHEQUE along with the binder/deposit cheque accompanying this application.

<< Sign Attached Pre-Authorized Debit (PAD) Agreement >>

PREMIUM SUMMARY

Table with 2 columns: Single Coverage, Family Coverage. Each column has a dollar sign followed by a blank line for input.

- Premiums subject to PST, if applicable
\$10.00 per month Standard Group Administration Fee, subject to GST
Rates are reviewed annually with adjustments being effective January 1st regardless of the effective date.

APPLICATION TO PARTICIPATE IN THE RWAM TRUST

WHEREAS:

- The Applicant desires to obtain the benefits requested in this Application as eligible graduating student(s) and their eligible dependents, and hereby applies to become a Participating Member under the Retailers, Wholesalers and Manufacturers Group Insurance Trust (the "RWAM Trust");
The agreement governing the RWAM Trust (the "RWAM Trust Agreement") provides that the trustees of the said trust, or their authorized agents, shall have the right and discretion to accept or reject applications from qualified persons to become Participating Members in the said trust from time to time;
Benefits provided by licensed insurers under group insurance contracts issued to the Trustees of the RWAM Trust (the "Trustees") include: group Extended Health Care coverage, group Dental coverage, group Life, group AD&D, and other standard and optional group insurance products;
RWAM Insurance Administrators Inc. ("RWAM") is the authorized agent of the Trustees of the RWAM Trust, and has been appointed as administrator of the RWAM Trust.

NOW THEREFORE, subject to the Applicant being accepted as a Participating Member in the RWAM Trust, THE APPLICANT ACKNOWLEDGES, UNDERTAKES AND AGREES:

- To be bound by all the terms, provisions, conditions and limitations of the RWAM Trust Agreement and any and all insurance contracts issued to the Trustees and all lawful amendments thereto;
To pay, or cause to be paid, all contributions and premiums necessary to provide the benefits applied for herein, or subsequently requested, as and when required by the Trustees pursuant to the terms thereof;
That the only benefits provided shall be in accordance with this Application as submitted. Any changes desired by the Applicant must be requested in writing and are subject to the approval of the Trustees or their authorized agent, and shall only be effective as of the date of such approval.
To hold open for inspection any records in its possession or under its control relating to this Application and the benefits hereby applied for or provided hereunder, and to co-operate fully with the Trustees, RWAM and their agents in all matters regarding the benefits applied for or provided.
At all times, to enroll only eligible graduating students and their eligible dependents for benefit coverage.
To immediately inform RWAM in writing of any changes to the Contributory or Non-Contributory status of its premiums or contributions, including any changes affecting the status, for tax purposes, of any benefits provided for under this Application.
To provide immediate written notification to RWAM of any person who ceases meet any eligibility requirements between the date this Application is signed and the date of acceptance of this Application.

The Applicant hereby appoints RWAM Insurance Administrators Inc. to act as its agent under the RWAM Trust Agreement, to act on the Applicant's behalf for the purposes of the said trust agreement, including, without limitation, any notice provisions or amendments thereto, save and except for any notice of default as to contributions or premiums, or any notice of termination as a Participating Member.

The Applicant hereby declares that, to the best of the Applicant's knowledge, the statements and answers contained in this Application are full, complete and true as of the date hereof.

Subject to this Application being approved, the effective date of coverage in respect of the benefits hereby applied for shall be the Policy Effective Date indicated in this Application.

In the event any errors or omissions are discovered in this Application, RWAM is hereby authorized to amend this Application by noting the required change(s) on this Application. A copy of this amended Application shall be sent forthwith to the Applicant, and such action shall constitute acceptance of such change(s), unless the Applicant provides immediate written notice to the contrary.

An initial Premium Binder/Deposit of \$ \_\_\_\_\_ (as per one month of estimated premium using quoted rates) is included with the Application.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_

Applicant (Full Legal Name)

Witness

Agent and Agency

RWAM Insurance Administrators Inc.
49 Industrial Drive, Elmira ON N3B 3B1
Fax: 519-669-1923 Ph: 519-669-1632 Toll-free: 1-877-888-RWAM (7926)
www.rwam.com



## Pre-Authorized Debit (PAD) Agreement

<b>PAYOR INFORMATION</b>
Name of Payor/Applicant _____
Group Benefits Plan: RWAM Graduating Student Conversion Plan

<b>PAYOR'S ACCOUNT INFORMATION</b>
Type of Account: Savings <input type="radio"/> Chequing <input type="radio"/> Other <input type="radio"/> _____
Account No _____
Branch Transit No. _____ Financial Institution No. _____
Name of Financial Institution _____
Address of Financial Institution _____
No. & Street <span style="float: right;">City</span>
Province <span style="float: right;">Postal Code</span>
<b>&lt;&lt;&lt; ATTACH A VOIDED BLANK CHEQUE TO THIS FORM &gt;&gt;&gt;</b>

### P.A.D. Authorization:

I authorize RWAM Insurance Administrators Inc. (RWAM) to debit the bank account identified above and/or shown on the attached void cheque for all monthly invoiced premiums in **the amount of \$\_\_\_\_\_** and any applicable taxes **on or about the 1st business day of every month**, for payment of the above named group benefits plan. I understand this authorization may be cancelled by providing written notice to RWAM at the address indicated below, at 30 days prior and no less than 10 days prior to the next scheduled debit.

I have waived the right to pre-notification of at least 10 days before my first PAD; however RWAM will send me monthly written invoices identifying any new premium amount/rate change at least 10 days before each and any change in the amount of my PAD.

My authorization may be revoked at any time in writing, subject to providing a notice period of 30 days to RWAM. To obtain a sample cancellation form or for information on my right to cancel a PAD agreement, I may contact my financial institution or visit [www.cdnpay.ca](http://www.cdnpay.ca).

I understand I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD agreement. If I wish to obtain more information on my recourse rights, I may contact my financial institution or visit [www.cdnpay.ca](http://www.cdnpay.ca).

These services are for (check one):  Personal Use  Business Use

Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_

Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_  
If joint account, additional signature required

Contact: RWAM Insurance Administrators Inc.  
49 Industrial Drive, Elmira ON N3B 3B1  
Fax: 519-669-1923-1923 Ph: 519-669-1632 Toll-free: 1-877-888-RWAM (7926)  
[www.rwam.com](http://www.rwam.com)



Enrolment Form

GRADUATE

PLEASE PRINT AND COMPLETE EACH SECTION CLEARLY IN INK

Surname First Name

Address No. and Street City/Town Province Postal Code

GRADUATION INFORMATION

Date of Graduation Degree Obtained

School of Graduation

GRADUATE'S DATA

NOTE: You must complete and submit a group Health Evidence form for you and any of your dependents for approval

Date of Birth Year Month Day

Marital Status:
q Married q Divorced q Separated
q Single q Widowed q Common-law\*
\*If Common-law, date co-habitation began:

Gender
m Male m Female

Year Month Day

If you are eligible for family coverage, your dependents must have coverage\* through your spouse
q SINGLE, Extended Health Care u Spouse's Employer
q SINGLE, Dental u Spouse's Group Insurance Carrier
\* If the comparable coverage ceases, advise RWAM within 31 days, or you will be required to submit medical health evidence (at your expense) and you will be subject to a one year dental restriction

Indicate if you have any coverage\* through your spouse:
Extended Health? q No q Yes Dental? q No q Yes
q FAMILY, Extended Health Care u If 'Yes' - Spouse's Group Insurance Carrier\*\*
q FAMILY, Dental u
\* If the comparable coverage ceases, advise RWAM within 31 days, or you will be required to submit medical health evidence (at your expense) and you will be subject to a one year dental restriction
\*\* Claims must first be submitted to the primary carrier indicated above. Any portion of the claim not reimbursed by the primary carrier, can then be sent to the secondary carrier for consideration. Eligible dependent children's claims are reimbursed under the parent whose date of birth falls first in the calendar year.

ELIGIBLE DEPENDENTS

NOTES: A dependent child must be under age 21. A child of a common-law spouse must reside with you. A dependent child under age 25 may be eligible if they are a full-time student and with proof of registration.

Table with 4 columns: Surname, First Name, Relationship to Graduate, Date of Birth (yyyy/mm/dd)

AUTHORIZATION

I understand the information I provide on this form will be used by RWAM Insurance Administrators Inc.(RWAM) and the insurer for the purposes of determining eligibility for group insurance coverage and benefits; and to administer benefits under this coverage. I hereby authorize my plan administrator, the authorized group agent/broker, and the insurer to exchange any relevant and necessary information for such purposes. If I am applying for coverage for my eligible dependents, I confirm I am authorized to act on their behalf for such purposes. I declare that the statements made on this form are complete and true. I understand that if any statement is incomplete or false, any coverage granted may be voided. This authorization will remain valid for as long as I am claiming benefits or service, or until revoked by myself.

Graduate's Signature Date

OFFICE USE ONLY

Table with 4 columns: Extended Health Care, Dental, Effective Date, Group/Certificate #

