Enrollment Card
Critical • Choice • Care™

RESET

Employer Section

Policy No. _____ Division/Unit _____

Employer _____ ID # _____

Applicant Section

Employee Name _____ Province of residence _____

Coverage ☐ Employee only ☐ Couple ☐ Family

Employee ☐ M ☐ F ☐ Smoker ☐ Non-Smoker

Amount of Principal Sum _____ Date of Birth D M Y

Dependent Child Rider ☐ Yes ☐ No

Amount of Principal Sum _____

Employee Signature _____ Date D M Y

Spouse ☐ M ☐ F ☐ Smoker ☐ Non-Smoker

Name _____

Amount of Principal Sum _____ Date of Birth D M Y

Spouse Signature _____ Date D M Y

☐ New Enrollment ☐ Change in Amount ☐ Change of Name

☐ I authorize the deduction from my salary of the premiums for the insurance applied for as shown above.

☐ I have been given the opportunity to apply for this insurance but I do not desire to participate.

Employee Signature _____ Date D M Y

Address _____

Street City Province Postal Code