

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



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

Basic Life:

	<u>Surname</u>	<u>Given Name</u>	<u>Relationship</u>
Beneficiary Designation →	_____		

Optional Life:

<input type="radio"/> I wish to participate	<input type="radio"/> I do not wish to participate	Have you smoked (cigarettes, cigars, pipe, etc) or used tobacco in any form within the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="radio"/> Non-Smoker	<input type="radio"/> Smoker		
<input type="radio"/> ½ times annual salary	<input type="radio"/> 1 times annual salary	<input type="radio"/> 1½ times annual salary	<input type="radio"/> 2 times annual salary

FOR PMA AND IUOE MEMBERS ONLY:

<input type="radio"/> 3 times annual salary	<input type="radio"/> 4 times annual salary	<input type="radio"/> 5 times annual salary
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	<u>Surname</u>	<u>Given Name</u>	<u>Relationship</u>
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:

	<u>Surname, Given Name</u>	<u>Date of Birth (YYMMDD)</u>	<u>Relationship</u>	<u>Student</u>	<u>Disabled</u>
Spouse → <input type="radio"/> Add <input type="radio"/> Delete	_____				
Dependent Child(ren) → <input type="radio"/> Add <input type="radio"/> Delete	_____ <input type="radio"/> <input type="radio"/>				
	_____ <input type="radio"/> <input type="radio"/>				
	_____ <input type="radio"/> <input type="radio"/>				

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

	<u>Surname</u>	<u>Given Name</u>	<u>Relationship</u>
Beneficiary Designation →	_____		

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

	<u>Surname, Given Name</u>	<u>Date of Birth (YYMMDD)</u>	<u>Relationship</u>	<u>Student</u>	<u>Disabled</u>
Spouse → <input type="radio"/> Add <input type="radio"/> Delete	_____				
Dependent Child(ren) → <input type="radio"/> Add <input type="radio"/> Delete	_____ <input type="radio"/> <input type="radio"/>				
	_____ <input type="radio"/> <input type="radio"/>				
	_____ <input type="radio"/> <input type="radio"/>				

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.

