SPECIAL RISK
INSURANCE MANAGERS

Personal Information for Employee of:

Surname	Given Name	Initials

Provincial Health Care No. (if applicable)

Gender MALE ○ FEMALE ○	Social Insurance Number:
Coverage Requested SINGLE ☐ COUPLE ☐ COUPLE+1 ☐ COUPLE+2 ☐ COUPLE+3 ☐ COUPLE+4 ☐	Date of Birth (M/D/Y)

Mailing Address **(Canadian and may be care/of)**

City/Province		Postal Code	
Email Address		Country of Foreign Assignment	
Business Phone Number		Home Country	
Date of Foreign Assignment	M/D/Y	Resident Phone Number	Fax Number
Occupation		Annual Income and Currency	

Daily duties and percentage of time spent in Office type environment:

Effective Date of Coverage (office use only)	M/D/Y	Effective Date of Dependent Coverage (if applicable)(office use only)	M/D/Y

Dependent Information (complete if Family or Couple selected)

Surname	Given Name	Date of Birth M/D/Y	Gender	Relationship to Insured	Provincial Gov't Health Care # (If applicable)	Country of Residence (If applicable)

Beneficiary Designation for Lloyd's of London (if Accidental Death & Dismemberment selected)

Surname	Given Name	Relationship to Insured	Address	Percentage

Personal Information for Employee of :

Surname	Given Name	Initials

Protecting Your Personal information

We recognize and respect your right to privacy. Therefore, when you apply for coverage, we establish a confidential file that is kept in our office. We limit access to information in your file to authorized persons who require the information to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use the information to determine your eligibility for coverage and to administer the group benefits plan.

Authorizations and Declarations

- I hereby apply for coverage under the group/individual benefits plan.
- I authorize:
  - Any healthcare provider, my plan administrator, other insurance companies, or benefits providers working with this plan to exchange information, when necessary to determine my eligibility for coverage and to administer the group benefits plan.
- If applying for coverage for my spouse and/or dependents, I confirm that I am authorized to act on their behalf.
- I certify that the information given is true, correct and complete to the best of my knowledge.

Applicant's Signature: *Date:*

I hereby certify that the information stated on this form is true and correct to the best of my knowledge. Unless otherwise stated, where two or more beneficiaries are named, the proceeds shall be paid in equal shares. This designation revokes any and all previous designations. The right to further change the beneficiary is reserved unto the insured.

Scan and email completed application to
mjohns@srim.ca
or if faxing
00-1-289-277 1384

Send original forms to
Mark Johns
Special Risk Insurance Managers Ltd.
Unit 22, 10 Sunray Street
Whitby, ON
L1N 9B5