

# CAIPW BENEFIT PLAN - TRANSACTION CARD

**EMPLOYER: PLEASE COMPLETE SHADED AREA**

EMPLOYEE/MEMBER - PLEASE COMPLETE ALL INFORMATION EXCEPT FOR SHADED AREAS.

LAST NAME

FIRST NAME

INITIAL

MALE  FEMALE

DATE OF BIRTH

MONTH

DAY

YEAR

BENEFICIARY DESIGNATION

I hereby revoke all previous beneficiary designations and designate the following as beneficiary(ies):

Beneficiary's name(s) Percent Relationship to applicant

Surname First Name Initial

Surname First Name Initial

To be divided  As per the percentages indicated above or,  In equal shares to the survivor(s)

You may change this beneficiary designation at any time by notifying CAIPW. If designating a beneficiary who is a minor or who lacks legal capacity, please complete declaration on reverse.

HAVE YOU EVER USED TOBACCO PRODUCTS? IF YOU USED TOBACCO PRODUCTS BUT STOPPED GIVE DATE STOPPED

YES  NO

This information is collected for the purpose of enrolling you and your eligible dependents in the benefit programs provided by your employer. Additional information may be required. If you have any questions about the information collected or the questions asked, please refer to CAIPW privacy policy.

FIRM NO.	CERT NO.	ACTION REQUESTED <input type="checkbox"/> ADD <input type="checkbox"/> CHANGE <input type="checkbox"/> DELETE	
DATE OF EMPLOYMENT (ADDS ONLY)		EFFECTIVE DATE OF CHANGE/DELETE	
WAGE <input type="checkbox"/> PER MONTH <input type="checkbox"/> PER YEAR	COVERAGE <input type="checkbox"/> EHC <input type="checkbox"/> SINGLE <input type="checkbox"/> FAMILY <input type="checkbox"/> DENTAL <input type="checkbox"/> SINGLE <input type="checkbox"/> FAMILY <input type="checkbox"/> DEP LIFE		
IF SPOUSAL EXEMPTION REQUESTED COMPLETE DECLARATION ON REVERSE			
STATUS: CA	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> PARTNER	<input type="checkbox"/> EMPLOYEE <input type="checkbox"/> CASB STUDENT
FOR CAIPW USE ONLY			
LIFE	ADD	LTD	EHC DEN
I hereby apply for the benefits provided by the policy or policies issued to my employer/association and authorize any deduction from my pay any contributions required to be made by me. I, the undersigned employee/member, hereby appoint the person stated as my beneficiary on my employer's/association's current and/or future insurance benefits and understand that I may, to the extent permitted by law, change my beneficiary at any time in the future.			MO. DAY YR.
APPLICANT	X		
EMPLOYER / WITNESS	▶		

S6016933QXD  
Data Group of Companies (780) 462-9700

## For Family EHC/Dental coverage Please complete the section below listing ALL ELIGIBLE DEPENDENTS (including spouse) (consult your booklet for a description of eligible dependents)

First Name	Initial	Surname	Relationship	Date of birth			Age 21-25* check box	Disabled check box
				Mo.	Day	Yr.		
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>

\*Indicate the name of school/university being attended

## Co-ordination of Benefits-complete only if family coverage has been selected

Does your **spouse** have coverage available under any other policy?

No  Yes, please indicate type of coverage  Medical  Dental

Do your **dependent children** have coverage available under any other policy?

No  Yes, please indicate type of coverage  Medical  Dental

