AUTOMOTIVE RETAILERS ASSOCIATION
GROUP ENROLLMENT FORM

☺ Please **PRINT** the following information clearly (type or use blue ballpoint pen). Initial any changes.
☺ Photocopy required number of copies onto plain paper for each employee to complete.
☺ Please sign, date and return original directly to:
Automotive Retailers Association, #1–8980 Fraserwood Court, Burnaby, BC V5J 5H7

Account Number Company Code		Class:		☐ New Applicant ☐ Reinstate ☐ Transfer from another ARA Group

1. EMPLOYEE DETAILS:

Last Name:			**Member ID (Social Insurance Number)**			
First Name		**Sex:** ☐ Male ☐ Female	**Date of Birth:**	Month	Day	Year
Marital Status:	☐ Single ☐ Widowed ☐ Separated ☐ Divorced ☐ Common-Law** ☐ Married**					
Mailing Address:						
City:		**Prov:**	**Postal Code:**		**Phone:** ( )	

** Please complete #3 below

2. EMPLOYMENT INFORMATION:

Employer:				**Occupation:**		
Date Employed Full Time:	Month Day Year	**Earnings:**	$	**Earnings Period**	☐ Year ☐ Semi-Monthly ☐ Weekly ☐ Monthly ☐ Bi-Weekly ☐ Hourly	**Hours Per Week:**
Extended Health Benefits: *(please choose one of the following)* ☐ Single ☐ Family** ☐ Waived**				**Dental:** *(please choose one of the following)* ☐ Single ☐ Couple** ☐ Family** ☐ Waived**		
Have you applied for Fair Pharmacare? ☐ No ☐ Yes ⇨ **Please supply Fair Pharmacare Number:**						

** Please complete #3 below

3. SPOUSE DETAILS **:

Spouse Last Name:		**Spouse First Name:**
Sex:	☐ Male ☐ Female	For Common Law Status: I, the undersigned, hereby certify that I have been living common-law with the above named spouse and representing him/her as my spouse or my common-law spouse. I certify that I do not have or wish to provide coverage to my otherwise legal spouse, if any. Employee Signature:
Spouse Date of Birth:	Month Day Year	

Do you or your spouse have coverage through another source?
Extended Health Benefits ☐ No ☐ Yes ⇨☐ Single☐ Family
Dental ☐ No ☐ Yes ⇨☐ Single☐ Family
If Yes: please complete this information ⇨

Other Source Plan Details: ☐ Spouse ☐ Parent ⇨_____
Employer:_____
ID Number: _____Insurance Company:_____Group Number:_____

4. CHILDREN DETAILS **:

Last Name	First Name	Sex	Date Of Birth Month	Day	Year	Student*** *(See below)*	Handicapped
		M F				Y N	Y N
		M F				Y N	Y N
		M F				Y N	Y N
		M F				Y N	Y N
		M F				Y N	Y N

*** Please provide documentation of full-time student status for dependent children between 20 and 25 years

5. BENEFICIARY DESIGNATION:

I hereby designate as revocable beneficiary in the event of my death: *{Please use full legal name(s)}*

Name:_____**Relationship:**_____

Name:_____**Relationship:**_____

IMPORTANT – You must sign and date the form

I hereby authorize the use of my social insurance number for internal identification purposes only. I am authorized to disclose information about my spouse and dependents in order to enroll them in my Benefits Plan. By enrolling in the Benefit Plans, I authorize the following 1) Sun Life Assurance Company of Canada, its agents and service providers to use and exchange information collected in this form to underwrite, administer and adjudicate claims 2) My employer and its agents to use the information collected in this form for benefits administration and to make any necessary payroll deductions which may be required 3) Sun Life Assurance Company of Canada, my employer and ARA to exchange information about me, my spouse and dependents necessary for enrolment and for the purposes of continuing administration of the Benefit Plans. I declare that the information provided in this form is true and accurate. A photocopy or electronic version of this authorization is as valid as the original and shall remain in effect until withdrawn by me in writing.

Signature:_____**Date Signed:**_____

(ARA USE ONLY)

ASSN	PART #	EFFECTIVE DATE MONTH	DAY	YEAR	CLASS	LIFE/AD&D NEM CURRENT VOLUME	NEEDS HQ ☐YES ☐ NO PROPOSED VOLUME	LTD NEM CURRENT VOLUME	NEEDS HQ. ☐YES ☐ NO PROPOSED VOLUME	DENTAL STATUS
BOOKLET SENT						MEMBER ID CARD			DRUG CARD SENT	

ADM 01 (09-09)