BRITISH COLUMBIA
PUBLIC SCHOOL
EMPLOYERS' ASSOCIATION
SOLUTIONS AT WORK

Application for Optional AD&D Insurance

Complete this form and return it to your plan administrator. No proof of insurability is required.
Note that the employee is automatically the beneficiary of any insurance covering a spouse or child under the family plan.

Employer

Employee Name

Address	Town/City
Province of residence	SIN
Birthdate *DD/ MM/ YY*	Gender □ M □ F

A Present amount of optional AD & D

$ ________________________________

B Additional amount being applied for

$ ________________________________

Total A and B

$ ________________________________

Optional AD & D Plan

□ Single □ Family

Beneficiary Name (Last / First / Initial)	Share of proceeds	Relationship	Name of Trustee for Beneficiares under 18

I hereby apply for optional AD & D insurance under my employer's group insurance plan and authorize required payroll deductions.

Signature

Date Signed
DD/MM/YY