



GROUP INSURANCE PLAN ENROLLMENT FORM

Administered By:



SECTION 1 - PLAN MEMBER INFORMATION [] ENROLLMENT [] CHANGE

Employer's Name, Date of Membership in the Association, Indicate if: Employee or Employer, Date of Hire, First Name, Initials, Last Name, E-mail Address, Date of Birth, Civil status, Gender, # of Hours Worked Per Week, Address (Street No. or P.O. Box), (City or Town), (Province), (Postal Code), (Telephone #):

SECTION 2 - ENROLLMENT INFORMATION

1. Are you currently participating in the RAMQ plan? YES NO
2. Are you currently participating in a Spousal Group Insurance Plan? YES NO
According to RAMQ legislation all Quebec residents under 65 years of age that have access to a group insurance plan, are obliged to join the group plan. If a person is covered by another group plan or if a person is covered by a spouse's group plan and wishes to waive the QFA Group Insurance Plan, proof of such coverage must be filed with your employer.
When filing your Quebec tax return, you will be asked if you have met the requirements according to this law.

Family coverage is mandatory if you have eligible dependents, unless covered elsewhere.
HEALTH [] Single [] Family [] Waive*
DENTAL [] Single [] Family [] Waive*
* If you have an involuntary loss of spousal coverage you must advise Johnson Inc. within 30 days from the date of cancellation
If waiving Health and Dental:
I wish to enrol in the Basic Life, Basic Accidental Death & Dismemberment and Dependent Life YES NO*
*If choosing no, any future application for this coverage will be subject to evidence of insurability.

SECTION 3 - SPOUSE AND DEPENDENT CHILDREN INFORMATION (if applicable)

Table with 6 columns: First Name, Initials, Last Name, Date of Birth (DD / MM / YY), Gender M / F, Overage Dependent Status (S-Student (age 21-26), D-Disabled). Rows for Spouse and Child.

SECTION 4 - BENEFICIARY DESIGNATION INFORMATION (must be completed)

In the province of Quebec, in the absence of an irrevocable / revocable designation, the legal spouse is deemed to be irrevocable and other beneficiaries are deemed to be revocable. An irrevocable designation cannot be changed without the beneficiary's written consent. Revocable / irrevocable must be hand written. You may also wish to designate a "Contingent Beneficiary (ies)" in the event there are no surviving Primary Beneficiary (ies) at the time of your death. Should there not be any surviving beneficiaries at the time of your death, proceeds will be paid to your estate.

BASIC LIFE
Full First and Last Name, Percentage, Relationship
Name a Trustee if Beneficiary is under age 18:
Contingent Beneficiary:

BASIC ACCIDENTAL DEATH & DISMEMBERMENT
Full First and Last Name, Percentage, Relationship
Name a Trustee if Beneficiary is under age 18:
Contingent Beneficiary:

SECTION 5 - AUTHORIZATIONS & DECLARATIONS

I hereby apply for benefits under the Quebec Farmers' Association Group Insurance Program and authorize any required payroll/bank deductions. In order to determine my eligibility for benefits and administer group benefit coverage(s), I give the Plan Administrator, Johnson Inc., (and any relevant insurer as may be applicable) consent to: Collect and communicate personal information about me from people or organizations including: any health care practitioner, medical facility or provider of health care/dental services, and provincial health insurance plan, insurance company or reinsurer, my plan sponsor or former plan sponsor, government agency, or financial institution(s). In applying for coverage for my spouse and/or dependents, I confirm that I have consented to collect, use and communicate personal information for the purposes and in the manner set out above. I acknowledge that more detailed information concerning how and why the Plan Administrator, Johnson Inc. collects, uses and discloses my personal information is available at www.johnson.ca. If I have declined coverage, I understand that I may not be able to obtain coverage at a later date if I change my mind. My ability to obtain coverage is subject to the specific requirements and rules of the applicable insurance program. I am so responsible for the decisions to decline or accept coverage reflected in this enrollment form. I understand that I may not claim for any loss or damage arising directly or indirectly from the elections made in this form or from participation in the Plan against the Quebec Farmers' Association Group Insurance program, the Quebec Farmers' Association Group Insurance Trustees or their successors or any service provider, employee or agent of the Plan or the Trustees. In signing this form I, and my spouse (if applicable) specifically release those parties from any such liability. The information given on this form is true, correct and complete to the best of my knowledge. I hereby acknowledge receiving the Disclosure Notice regarding MIB Inc. (Medical Information Bureau)

MEMBER / EMPLOYEE SIGNATURE SPOUSAL SIGNATURE (IF APPLICABLE) DD / MM / YY