

WCASA BENEFIT PLAN - TRANSACTION CARD

EMPLOYER: PLEASE COMPLETE SHADED AREA

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

SURNAME

FIRST NAME

MIDDLE NAME

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 Last Name Middle Initial _____

Surname Last Name Middle 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 WCASA. 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 WCASA's 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 YES NO PARTNER EMPLOYEE CASB STUDENT

FOR WCASA 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.*

APPLICANT	MO.	DAY	YR.
EMPLOYER / WITNESS			

56016933QXD
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			If dependent is	
				Mo.	Day	Yr.	Age 21-25* check box	Disabled check box
_____	_____	_____	_____	_____	_____	_____	<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

