STANDARD LIFE

Group Life & Health

Refusal to join

Warning to the plan administrator:
Please read the following carefully before having this form completed by an employee.

Before having this form completed by an employee who refuses to join the group insurance plan, please verify the **minimum participation required by your plan**. For this, consult the "General Provisions" section of your group insurance policy under "Particulars".

- **100% participation**

If the number of participants under the terms of your policy is 100 % of eligible employees, please explain to your new employee that participation in your insurance plan is mandatory and that it is a condition of employment. Have your employee complete an **Application form**.

Note: For each employee who refuses to sign an Application form, please provide us with an explanation of the reasons by completing a **Notice of change form G1285**.

- **Less than 100% participation**

If you meet the minimum participation conditions required, please have the employee complete and sign this **Refusal to join** form. Keep the form in your files and send a copy to Standard Life.

Note: Notify your employee that, in order to join the plan later, he/she will have to submit satisfactory evidence of insurability.

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☐ **All benefits** (complete sections **I** and **II**) ☐ **Voluntary benefits** (complete sections **I** and **III**)

I Administrative information *(please print)*

Policyholder name		Policy no.	Division no.	Certificate no.
Participant surname	Given name(s)		Initial	Date of birth *(YYYY/MM/DD)*

II Refusal to join *(Policies with voluntary participation: less than 100%)*

Statement	*I have reviewed all of the benefits provided under the above-numbered group policy. However, I prefer not to join the plan. I am aware that the policyholder shall have no obligation to replace the benefits to which I would have been entitled by participating in this plan and that I will be required to provide satisfactory evidence of insurability in order to join the plan at a later date.*

Signature of participant	Date *(YYYY/MM/DD)*
Signature of plan administrator	Date *(YYYY/MM/DD)*

Employees residing in Québec are required to subscribe to the plan if the policy provides for the reimbursement of the cost of prescription drugs. Please note that, further to the Québec government's adoption of the *Act respecting prescription drug insurance*, it is mandatory for all employees eligible for a group insurance plan to be covered by prescription drug insurance unless they are covered by a health insurance plan provided by their spouse's insurance company or any recognized group insurance plan.

III Refusal to join *(voluntary benefits)*

Statement	*I have reviewed all of the benefits provided under the above-numbered group policy. However, I prefer not to be covered for the voluntary benefits mentioned below. I am aware that the policyholder shall have no obligation to replace the coverage to which I would have been entitled by participating in these voluntary benefits and that I will be required to provide satisfactory evidence of insurability if I apply for coverage under these benefits at a later date.*

Refusal for ✓ Specify

☐ Life and Accidental Death and Dismemberment ☐ Health
☐ Long-Term Disability ☐ Dental

Signature of participant	Date *(YYYY/MM/DD)*
Signature of plan administrator	Date *(YYYY/MM/DD)*