Clear Data - Effacer l'information

Protected "B" when completed

PUBLIC SERVICE MANAGEMENT INSURANCE PLAN

1. ☐ INITIAL APPLICATION 2. ☐ CHANGE IN COVERAGE 3. ☐ TOTAL CANCELLATION

* PLEASE INDICATE ALL COVERAGE REQUESTED WHEN AMENDING

For Departmental Use Only

IAN	Superannuation No.	Dept. No.	Paylist No.	Date received (Y-M-D)	Init.

To Be Completed by the Applicant (Please Print)

Name and Initial	Surname	Date of Birth (Y-M-D)	Sex
			☐ M ☐ F

Mailing Address

Name of Beneficiary	Relationship

I reserve the right to revoke this beneficiary appointment (for initial application only) ☐ YES ☐ NO

	YES	NO
Employee coverage (I hereby apply for Basic Life Insurance and for the optional coverage indicated below):		
Supplementary Life Insurance (Declaration of Health [PWGSC-TPSGC 2028-2] required)	☐	☐
Accidental Death and Dismemberment Insurance - In units of $25,000 up to a maximum of 10 (insert the number of units in the "yes" box)		☐

Dependant's Insurance: 1 - Spouse and Children, 2 - Children Only ☐

I am (I am not) insured under an employee organization group insurance plan. My last day of coverage is (Y-M-D)

☐ I authorize the appropriate Pay Agency to deduct from my pay the necessary premiums. This authorization shall continue until revoked by me in writing.

☐ I hereby cancel my insurance.

Date _____ Signature _____

For Departmental Use Only

Date on which the employee was taken on strength in the Public Service (Y-M-D) _____

Date on which the employee became eligible to apply for PSMIP (Y-M-D) _____

Date _____ Signature _____ Location _____

Department or Agency _____ Tel. No. _____

Complete Address of Department or Agency _____

PSMIP

Name and Address	IAN
	Paylist No.

☐ 1. This acknowledges receipt of your application card on _____ Date (Y-M-D)

☐ 2. Please submit a Declaration of Health (PWGSC-TPSGC 2028-2).

_____ Date

_____ Personnel Officer