AUTOMOTIVE RETAILERS ASSOCIATION
Driving Industry Excellence

AUTOMOTIVE RETAILERS ASSOCIATION
GROUP ENROLMENT FORM

- Please complete the following information and initial any changes.
- Print on plain paper and sign in ink to authenticate. **(Please note: digital signatures are not valid on this form.)**
- Please sign and date the form, then send the original to: **Automotive Retailers Association, #1–8980 Fraserwood Court, Burnaby, BC, V5J 5H7.**

Account Number Company Code:		**Class:**		☐ **New Applicant**	☐ **Reinstate**	☐ **Transfer from another ARA Group**

1. EMPLOYEE DETAILS

Last Name:			**Member ID:** (Social Insurance Number)			
First Name:		**Gender:** ☐ Male ☐ Female	**Date of Birth:**	Month	Day	Year
Marital Status:	☐ Single ☐ Widowed ☐ Separated ☐ Divorced ☐ Common-Law** ☐ Married**					
Mailing Address:						
City:		**Province:**	**Postal Code:**	**Home Phone:**		
Email Address:				**Cell Phone:**		

** Please complete #3 below

2. EMPLOYMENT INFORMATION

Employer:						**Occupation:**			
Date Employed Full Time:	Month	Day	Year	**Earnings:**	$	**Earnings Period:**	☐ Year ☐ Semi-Monthly ☐ Weekly ☐ Monthly ☐ Bi-Weekly ☐ Hourly	**Hours Per Week:**	
Extended Health Benefits: *(please choose one of the following)* ☐ Single ☐ Family** ☐ Waived**						**Dental:** *(please choose one of the following)* ☐ Single ☐ Couple** ☐ Family** ☐ Waived**			
Have you applied for your Provincial Pharmacare? ☐ No ☐ Yes ➔ **Please supply Number and/or letter:**_____									

** Please complete #3 below

3. SPOUSE DETAILS **

Spouse Last Name:			**Spouse First Name:**		
Gender:	☐ Male ☐ Female		***For Common Law Status:*** I, the undersigned, hereby certify that I have been living common-law with the above-named spouse and representing him/her as my spouse or my common-law spouse. I certify that I do not have or wish to provide coverage to my otherwise legal spouse, if any.		
Spouse Date of Birth:	Month	Day	Year	**Employee Signature:**_____	
Do you or your spouse have coverage through another source? Extended Health Benefits ☐ No ☐ Yes ➔ ☐ Single ☐ Family; Dental ☐ No ☐ Yes ➔ ☐ Single ☐ Family. **If Yes:** please complete this information ➔				***Other Source Plan Details:*** ☐ Spouse ☐ Parent ➔ _____ Employer:_____ ID Number:_____ Insurance Carrier:_____ Group Number:_____	

4. CHILDREN DETAILS ***

Last Name	First Name	Gender	Date of Birth Month	Day	Year	Student*** *(See below)*	Disabled
		☐ M ☐ F				☐ YES ☐ NO	☐ YES ☐ NO
		☐ M ☐ F				☐ YES ☐ NO	☐ YES ☐ NO
		☐ M ☐ F				☐ YES ☐ NO	☐ YES ☐ NO
		☐ M ☐ F				☐ YES ☐ NO	☐ YES ☐ NO

*** Please provide documentation of full-time student status for dependent children between 20 and 25 years

5. BENEFICIARY DESIGNATION

I hereby designate as revocable beneficiary in the event of my death: *{Please use full legal name(s)}*

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

IMPORTANT – Please sign and date the form. Note that digital signatures are not valid on this form.

I hereby authorize the use of my social insurance number for internal identification purposes only. I am authorized to disclose information about my spouse and dependents in order to enroll them in my Benefits Plan. By enrolling in the Benefit Plans, I authorize the following 1) Sun Life Assurance Company of Canada, its agents and service providers to use and exchange information collected in this form to underwrite, administer and adjudicate claims 2) My employer and its agents to use the information collected in this form for benefits administration and to make any necessary payroll deductions which may be required 3) Sun Life Assurance Company of Canada, my employer and ARA to exchange information about me, my spouse and dependents necessary for enrolment and for the purposes of continuing administration of the Benefit Plans. I declare that the information provided in this form is true and accurate.

Signature:_____ **Date Signed:**_____

(ARA USE ONLY)

ASSN	PART#	EFFECTIVE DATE MONTH	DAY	YEAR	CLASS	LIFE/AD&D NEM	NEEDS HQ ☐ YES ☐ NO	LTD NEM	NEEDS HQ ☐ YES ☐ NO	DENTAL STATUS
						CURRENT VOLUME	PROPOSED VOLUME	CURRENT VOLUME	PROPOSED VOLUME	
BOOKLET SENT						MEMBER ID CARD		DRUG CARD SENT		

ADM 01 (07-2023)