



MEMBER ENROLMENT FORM

Aspiria Best Doctors ACE Canada

Association Information

Association: _____ Association of Dental Technologists of Ontario _____

RDT# _____ Associate # _____ Effective Date of Coverage _____

Member Information

Last Name _____ First Name _____

Date of Birth (DD/MM/YY)

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 Gender Male Female

Telephone Number _____ Home Work Cell

Street Address _____

City _____ Postal Code _____ Province _____

Spousal Information

Last Name _____ First Name _____

Date of Birth (DD/MM/YY)

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 Gender Male Female

Beneficiary Designation

Under the terms of the Master Policy, I hereby designate my beneficiary(s):

Last Name _____ First Name _____ % allocated _____ % Relationship _____

Last Name _____ First Name _____ % allocated _____ % Relationship _____

Last Name _____ First Name _____ % allocated _____ % Relationship _____

The original of this form will be required in the event of an AD&D claim.

Crossed out or corrected beneficiary designations must be initialed.

PRIVACY STATEMENT: The information requested on and in respect of this application is required by Skipwith & Associates and ACE INA Life Insurance, its reinsurers and authorized administrators ("ACE"), for insurance purposes including, considering and if approved, processing this application, administering any coverage if issued, and investigating coverage and claims. Skipwith & Associates and ACE will also consult its existing files for these insurance purposes. Access to these files will be restricted to Skipwith & Associates Insurance Agency Inc. and ACE employees, authorized agents and reinsurers who require access to administer the Plan and process claims and persons authorized by law.

Member's Signature _____ Date (DD/MM/YY) _____