McMaster University
Human Resources Services

Life Event Change

Marriage or Common Law Relationship

A life event can affect your pension, benefits and other information at McMaster. Please carefully review each form included in this package and complete as applicable to update information with Human Resources. Some forms can be completed with a digital signature. To enable this feature, please save a copy of this package to your personal folder before completing.

Type of Change: ☐ Marriage ☐ Common Law Declaration

Effective Date: ____________

Field	Example	To input:
Salutation	*Mr.*	
First Name	*John*	
Last Name	*Doe*	
McMaster ID#	*1010101*	
Date of Submission	*September 1, 2007*	
Street	*123 Green Road*	
City	*Hamilton*	
Province, Country	*Ontario*	-
Postal Code	*L9D 7V7*	
Phone Number	*(905) 385-8888*	
Department/Faculty	*Hospitality Services*	
Status at McMaster	*Check Staff or Faculty*	☐ Staff ☐ Faculty
Employee Group	*TMG, Unifor, etc.*	
SIN	*505 258 258*	
Date of Birth (DOB)	*May 30, 1945*	
Gender	*Female*	
Citizenship	*Canadian*	
Marital Status	*Married*	

Fields that need to be entered for **Spouse** (only):

Field	Example	To input:
First Name	*Jane*	
Last Name	*Doe*	
Relationship	*Wife*	
DOB	*January 15, 1949*	

Emergency Contact:

Field	Example	To input:
First Name	*Jane*	
Last Name	*Doe*	
Relationship	*Wife*	
Telephone Number	*905-555-6666*	

NAME CHANGE FORM

This form is to be completed by the employee to notify McMaster University of a legal name change and submitted along with a copy of approved documentation. For additional information please contact your HR Advisor.

PART A **NAME CHANGE INFORMATION**

Previous Name:		
First Name:	**Last Name:**	**Middle Name:**
New Name:		
Last Name:	**First Name:**	**Middle Name:**
Employee ID	**Department**	**Campus Address**

PART B **DOCUMENTATION OF NAME CHANGE**

This form must be submitted with one of the following approved types of documentation:

- ☐ **Certificate of Marriage, Marriage Statement**
- ☐ **Legal Change of Name certificate or Court Order Document**
- ☐ **Passport***
- ☐ **Permanent Resident Card**
- ☐ **Driver's License (Enhanced or Other)***
- ☐ **Health Card***

***Documentation must be valid. Expired documentation will not be accepted.**

Employee Signature **Date**

PART E **HUMAN RESOURCES VERIFICATION**

Human Resources Signature **Date**

Date Stamp

NOTICE OF COLLECTION OF PERSONAL INFORMATION

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EMPLOYEE CONTACT & DEPOSIT INFORMATION FORM

Please forward to your Human Resources Services Area Office

A EMPLOYEE STATUS

New Employee	Effective Start Date (mm/dd/yyyy)	Department
Returning Employee	Effective Start Date (mm/dd/yyyy)	Department
Current Employee	Effective Date of Change (mm/dd/yyyy)	

B EMPLOYEE INFORMATION

Employee ID (if known)	Student ID (if applicable)		SIN (### ### ###)	SIN Expiry Date (yyyy-mm-dd)
Salutation	Legal First Name	Preferred Name*	Legal Middle Name*	Surname
Gender	Date of Birth (mm/dd/yyyy)		Marital Status	
Citizenship Country	Status if Not Canadian (Please attach copy of Permanent Resident/Work or Student Authorization)		Email Address	

*Not a required field. HR and Payroll related reporting and communications will normally use the Legal First Name (e.g. for tax reporting to CRA)

C MAILING ADDRESS

No. & Street	City	Province
Country	Postal Code (### ###)	Telephone No. (###) ###-####

D PERMANENT ADDRESS *(If different from mailing)*

No. & Street	City	Province
Country	Postal Code (### ###)	Telephone No. (###) ###-####

E EMERGENCY CONTACT INFORMATION

Name	Relationship
Telephone No. (###) ###-####	Alternate Telephone No. (###) ###-####

EMPLOYEE CONTACT & DEPOSIT INFORMATION FORM

Please forward to your Human Resources Services Area Office

F	DEPOSIT INFORMATION
Note: McMaster pays employees by direct deposit. This ensures employees receive their pay on the pay date. It also avoids lost or stolen cheques and forged endorsements.	
ATTACH VOID CHEQUE HERE	
Employee Signature	Date (mm/dd/yyyy)

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FOR HR USE ONLY		
Position Code	Recruitment Posting No.	Cumulative Service Date (mm/dd/yyyy)
Completed By		Completion Date (mm/dd/yyyy)
Comments		

DECLARATION OF SPOUSAL STATUS

☐ **Enrollment** - select this box if you are completing this form at the time of enrollment

☐ **Change in Spousal Status** - select this box if you are competing this form because of a change in your spousal status or change in spouse

EMPLOYEE INFORMATION

Last Name | **First Name** | **Initials**

Address

PART A: PENSION PLAN

For the purposes of McMaster's **Pension Plan**, an eligible **Spouse** is defined to mean someone who:

(1) is married to you; **or**

(2) is not married to you, but is living with you in a conjugal relationship either:

(a) for a continuous period of at least one year; or

(b) in a relationship of some permanence, if the two of you are the "*parents of a child*" as set out in Section 4 of the Children's Law Reform Act (refer to the last page for an explanation of what "parents of a child" means).

However, a person described above will not qualify as your eligible Spouse if he/she is *separated* from you.

Based on the above definition of eligible Spouse, please declare your spousal status by selecting one of the following boxes:

☐ I do not have an eligible Spouse as defined above

☐ The person named below is my eligible Spouse:

Last Name of Spouse | **First Name of Spouse** | **Date of Birth (MM/DD/YYYY**

PART B: HEALTH AND DENTAL BENEFITS

For the purposes of McMaster's **Health and Dental Benefit** plans, a dependent **Spouse** is defined to mean someone who:

(1) is married to you (or is your spouse under another formal union recognized by law); **or**

(2) has been publicly represented as your spouse for at least one year.

However, a person described above will cease to qualify as your dependent Spouse upon divorce, or if you are not married, on the 90th day after this person ceases to be publicly represented as your spouse.

Based on the above definition of dependent Spouse, please declare your spousal status by selecting one of the following boxes:

☐ I do not have a dependent Spouse as defined above

☐ The person named below is my dependent Spouse:

Last Name of Spouse | **First Name of Spouse** | **Date of Birth (MM/DD/YYYY**

INSTRUCTIONS:

Complete both Part A and Part B of this form.

Please note that the definitions of **"Spouse"** under Part A and Part B are **different**. It is possible that a person may qualify as your "Spouse" under Part B for the purposes of McMaster's Health and Dental Benefit plans, but not for the purposes of McMaster's Pension Plan. Please carefully read each of the definitions under Part A and Part B before completing this form.

Meaning of **"married"** (Part A and Part B) – this includes a marriage that was performed in a jurisdiction outside of Canada if the marriage is recognized as legal under the laws of the other jurisdiction.

Meaning of **"parents of child"** (Part A only) – you and your partner are considered to be "parents of a child" under section 4 of the Children's Law Reform Act if one of the following applies:

- you and your partner are the birth parents of a child; or
- your partner's sperm resulted in the conception of your child conceived through sexual intercourse (unless both of you agree in writing before the child is conceived that your partner will not be parent of the child); or
- you and your partner have consented to be parents of a child that was conceived through assisted reproduction or insemination; or
- you and your partner have signed a "pre-conception parentage agreement" before conception of a child; or
- you and your partner are the intended parents under a "surrogacy agreement"; or
- either you or your partner has been declared a parent of the other's child by a court, or
- you and your partner are the adoptive parents of a child under an adoption order.

If you and your partner are living together in a relationship of some permanence, and any one of the above applies, then your partner will qualify as your eligible "Spouse" under Part A for the purposes of the Pension Plan.

SIGNATURE:

I certify that the information which I have provided in this form is true and accurate.

Name of Employee (Print)

Employee ID Number

Signature of Employee

Date (MM/DD/YYYY)

EXTENDED HEALTH AND DENTAL POSITIVE ENROLMENT FORM

Please complete this form to enroll you and your eligible dependents into the Active Extended Health and Dental Plans, and return it to Human Resources Services. Claims cannot be processed for spouses and/or dependents who are not listed on this form. In cases of a new spouse, new child, overage or disabled child, coverage can be retroactive to the date of the change if we are notified within 31 days of such change. **This form replaces any previous information provided.**

This application, if approved enrolls me in or continues my coverage in the following plans:

Extended Health (Please choose one) ☐ **Family** ☐ **Single**

Dental (Please choose one) ☐ **Family** ☐ **Single**

PART A GENERAL INFORMATION

Policy Number		Last Name	First Name	Employee ID
25018				
Employee Group	**Extension**	**Department**	**Date of Birth (MM/DD/YYYY)**	**Gender** ☐ Male ☐ Female

PART B SPOUSE DETAILS (see definitions on reverse for further explanation prior to completion)

Last Name	First Name	Date of Birth (MM/DD/YYYY)	Gender	Relationship (wife, husband, common law)
			☐ Male ☐ Female	

If Spouse Works, Employer Name	Enrolled in their own Group Plan? (Please check appropriate box)
	Extended Health ☐ Family ☐ Single ☐ None Dental ☐ Family ☐ Single ☐ None

PART C DEPENDENT DETAILS (see definitions on reverse for further explanation prior to completion)

Last Name	First Name	Date of Birth (MM/DD/YYYY)	Overage Student (Y/N)	Disabled (Y/N)	Gender (Male/Female)

I understand it is my responsibility to notify the University of any addition or deletion from those I wish covered under the Plan. The insurer reserves the right to obtain reimbursement from me for any benefits paid due to error, misrepresentation or lack of notification.

______________________________ Employee Signature

______________________________ Date

PART D HUMAN RESOURCES VERIFICATION

______________________ Employee Start Date

______________________________ Human Resources Signature

~ Entered into Mosaic

DATE STAMP

Effective date of coverage not before date rec'd in HR unless a newly acquired dependant

ELIGIBILITY DEFINITIONS AND CO-ORDINATION OF BENEFITS INFORMATION

DEFINITION OF A SPOUSE

For the purpose of all benefit programs, at any given time a member may qualify no more than one spouse for the purpose of dependent coverage. To qualify, a person must satisfy the definition of "spouse" set out below:

"spouse" means:

1. a person who is married to you (or is your spouse by marriage under any other formal union recognized by law); or
2. a person who has been publicly represented as your spouse for at least the last 12 months.

Note: For information purposes, the employee's married spouse ceases to be eligible for benefit coverage when the employee and such spouse are divorced. If the employee is not married, the employee's spouse ceases to be eligible for benefit coverage on the 90th day after such person is no longer publicly represented as the spouse of the employee.

Both Spouses Employed at McMaster University If both you and your spouse are covered as subscribers under Policy 25018 (i.e. Each have your own coverage as an employee of the University), each spouse is considered to have their own plan when completing the Spouse Details section.

DEFINITION OF DEPENDENT CHILDREN

A dependent means your children and your spouse's children (other than foster children) who are unmarried and under age 21 (or up to age 25 in the case of a full-time student attending an education institution recognized under the Income Tax Act who is entirely dependent on the member for financial support) and for whom you have actual custody or legal financial responsibility. This includes legally adopted children and children for whom you are the legal guardian.

If a dependent child becomes handicapped before the limiting age, coverage will continue so long as:

- the child is incapable of financial self-support because of a physical or mental disability, and
- the child depends on you for financial support, and is not married nor in any other formal union recognized by law..

This is subject to the University/Insurer receiving proof from the member of the dependent child's incapacity no later than 31 days after the dependent child attains the limiting age.

Overage Student If your child is between the ages of 21 and 25 and in fulltime studies, please so indicate on the enrolment form in the Over age Student column.

Disabled Child If your child became disabled prior to the attainment of the limiting age, please so indicate on the enrolment form in the Disabled column.

Other Group Plans Where your child is covered under another group plan, separate from your current spouse's plan, please so indicate on the enrolment form under Other Group Plans. Space is available for Major Medical and Dental. Examples of this would be Student Drug/Health Plans offered at some Universities or coverage provided for a child through a former spouse.

CO-ORDINATION OF BENEFITS

Extended Health and Dental plans make provisions for those situations when an employee and his/her spouse both have plans available to them through their employers. Co-ordination of benefits is a means of dividing responsibility for payment between the two programs involved so that the combined coverage will pay up to 100% of the eligible expenses within the limits of both programs and not to exceed the total expense incurred. Eligible expenses include all items of care covered in whole or in part by at least one of the programs.

Responsibility for payment is determined by differentiating between primary and secondary responsibility between applicable programs. The primary program is responsible for paying as if there were no other program. The secondary program extends the coverage provided by the primary program.

When a patient is covered by two different contracts for benefits, it should be determined which contract carrier is responsible for primary liability for services performed. The protocol for determining the primary carrier which is described here is in compliance with the guidelines established by the Canadian Life and Health Insurance Association (CLHIA).

The basic rules are:

1. When an individual is covered by two plans, as a subscriber and as a spouse or dependent, the plan covering the individual as a subscriber is considered primary.
2. If the patient is a dependent child and both mother and father have a contract covering the child, then the contract of the parent whose birthday is first in the calendar year is considered primary. (For example, if John Doe's birth date is May 1, 1954 and his spouse's birth date is July 1, 1952, John's policy would be considered primary).
3. If the patient is a dependent child of divorced or separated parents, then the order of benefit determination is (a) the parent who holds custody or legal financial responsibility for the child, then (b) the plan of the spouse or parent with custody, and finally (c) the plan of the parent not having custody.
4. If the patient has two policies in his or her name, then the contract in effect for the longest period of time is considered primary.

When submitting claims for co- ordination of benefits, submit first to the primary plan and once payment is received, submit a copy of the receipts along with a copy of the payment from the primary plan to the secondary plan.

If you have questions regarding primary/secondary plans and coordination of benefits, please contact your insurance companies directly for assistance in determining the correct order of claims submission.

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GROUP LIFE INSURANCE PLAN

ENROLMENT FORM/BENEFICIARY CHANGE FORM

ALL EMPLOYEES MUST COMPLETE PARTS A, B and C,
PART D WILL BE COMPLETED BY HUMAN RESOURCES

PART A GENERAL INFORMATION

Policy Number		Last Name	First Name	Employee ID
50813				
Employee Group	**Extension**	**Department**	**Date of Birth (MM/DD/YYYY)**	**Gender** Male Female

PART B COVERAGE ELECTIONS

I apply for the benefits elected below as provided by the applicable policy. I authorize the university to deduct regularly from my pay any contributions required to be made under the Optional Life Plan. This election does not prevent me from applying for a change in group life coverage in the future. Such coverage will not become effective until such election form is received and approved by Sun Life.

Group Life Insurance Options

I understand that I will be enrolled in the basic group life plan offered by McMaster University and I elect the following options:

I waive the opportunity to increase my level of coverage under the Optional Life Plan.

I elect ______% of salary under the optional life plan, have completed the Sun Life Financial Statement of Health, **and have submitted the form directly to Sun Life Financial**. I understand that under the Optional Life Plan, coverage is subject to evidence of insurability And will not take effect until Sun Life notifies the University of your successful application.

Beneficiary Change Only.

PART C BENEFICIARY APPOINTMENT

For Life Insurance that becomes payable as a result of my death, I designate the following person(s) to be the beneficiary(ies):

Last Name	First Name And Initials	Relationship	Entitlement %

If you have not named a beneficiary, the benefit amount will be paid to your estate. You can change your beneficiary at any time, unless a law prevents you from doing so or you indicate the beneficiary is not to be changed.

I authorize McMaster University, Sun Life Financial; their agents and service providers to use and exchange the information collected in this form for the administration of Group Life Insurance (basic and optional coverage).

The information gathered on this form is collected under the authority of the *McMaster University Act*, 1976. The information is used for the academic, administrative, employment-related, financial and/or statistical purposes of the University including, but not limited to, admissions; registration and maintaining records; awards and scholarships; convocation; provision of student services, including access to information systems; alumni relations; and disclosure to or on behalf of the applicable McMaster student government. This information is protected and is being collected pursuant to section 39(2) and section 42 of the *Freedom of Information and Protection of Privacy Act* of Ontario (RSO 1990). Questions regarding the collection or use of this personal information should be directed to the University Secretary, Gilmour Hall, Room 210, McMaster University.

______________________________ Employee Signature

______________________________ Date

Please print and sign this form. This form does not have legal effect until Human Resources receives the signed form. You may either mail the original signed form to Human Resources or email a scanned version of the signed original to Human Resources.

DATE STAMP

PART D HUMAN RESOURCES VERIFICATION

______________________________ Human Resources Signature

~ Entered into Mosaic

VOLUNTARY PERSONAL ACCIDENT INSURANCE

(Accidental Death and Dismemberment – AD&D)

Enrolment Form/Change of Beneficiary Form

PART A GENERAL INFORMATION

POLICY NUMBER 50813	Last Name	First Name	Employee ID
Extension	Department	Date of Birth (MM/DD/YYYY)	

PART B COVERAGE ELECTION

The Voluntary Personal Accident Insurance benefits have been explained to me and I understand the options available to me. Based on this information, I apply for the benefits elected below as provide by the applicable policy. I authorize the University to deduct regularly from my pay any contributions required to be made by me under the Voluntary Personal Accident Insurance Plan. Coverage becomes effective on the 1st of the month following the date your completed Enrolment form is received by Human Resources. It may only be increased or decreased once a year on July 1st or if I have a change in Family Status.

I choose to enroll in
- ☐ Plan I (Employee Only)
- ☐ Plan II (Employee and Family)

Principal Sum Amount $ ______________________________

☐ I have been given the opportunity to apply for this insurance but I do not desire to participate.

☐ Beneficiary Change Only

PART C BENEFICIARY APPOINTMENT

For accidental death benefits becoming payable as a result of my death, I designate the following person(s) to be the beneficiary(ies):

Last Name	First Name And Initials	Relationship	Entitlement %

If you have not named a beneficiary, the Loss of Life Benefit will be paid to the first surviving class in the following order: spouse, surviving children, surviving parents, surviving siblings, estate.

I authorize McMaster University; Sun Life Financial; their agents and service providers, to use and exchange the information collected in this form for the administration of Voluntary Personal Accident Insurance.

______________________________ ______________________________

Employee Signature Date

Please print and sign this form. This form does not have legal effect until Human Resources receives the signed form. You may either mail the original signed form to Human Resources or email a scanned version of the signed original to Human Resources.

DATE STAMP

PART D HUMAN RESOURCES VERIFICATION

____

Human Resources Signature

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Voluntary Accidental Death and Dismemberment

Sun Life Assurance Company of Canada

DISCLAIMER: If there is a discrepancy between this summary and the policy booklet, the booklet prevails.

Scope of Coverage

Accidental Death and Dismemberment coverage provides benefits if, due to an accident occurring while covered, you or one of your dependents die or suffer any of the losses listed in the *Table of Losses.* Any death benefit paid under this coverage is in addition to the Life coverage.

Eligibility

All active full-time or regular part-time employees, their spouses and dependent children under 21 years of age (under 25 years if a full-time student at an Institution of higher learning) are eligible. If a child becomes handicapped before the limiting age they will remain covered if they are permanently mentally or physically challenged and incapable of self-support.

Plan Benefit Amount & Options

Employee Benefit Amount: An eligible employee may select benefit amounts in increments of $10,000, subject to a maximum amount of $500,000.

Adding Family Members for Coverage: There are 2 options from which to choose. In the option where family members can be included, the eligible employee selects their own benefit amount and the family member's benefit amount is an automatic percentage of the employee's benefit amount as follows:

Option A) Employee Only – Covers the employee for the benefit amount selected.

Option B) Family – Covers the employee for the benefit amount selected and:

i. The spouse for 50% of the employee's benefit amount and each dependent child for 15% of the employee's benefit amount;
ii. The spouse for 60% of the employee's benefit amount if only a spouse;
iii. Each dependent child for 20% of the employee's benefit amount if only dependent child(ren)

This benefit will be paid if you or one of your dependents:

- accidentally drown.
- disappear in an accident while travelling. This only applies if the means of transportation disappears, sinks, is wrecked, forced to land or stranded and the body is not found within one year. There must be no evidence that you or your dependent are still alive.
- are in an accident or exposed to the elements and, as a direct result, you or a dependent suffer one of the losses listed below within one year of that accident or exposure.

The amount that will be paid is a percentage of the Accidental Death and Dismemberment coverage. The percentage depends on the loss suffered. The following table shows the percentages that is used to determine the payment.

AMOUNT OF BENEFIT FOR EMPLOYEE AND SPOUSE

Table of Losses

Loss of life	100%
Loss of both arms or both legs**	200%
Loss of both hands or both feet	100%
Loss of one hand and one foot	100%
Loss of one hand or one foot, and entire sight of one eye	100%
Loss of one arm or one leg	80%
Loss of one hand or one foot	75%
Loss of four fingers on the same hand	33%
Loss of all toes on the one foot	25%
Loss of use of both arms or both legs or combination of one arm and one leg**	200%
Loss of use of both hands or both feet or a combination of one hand and one foot	100%
Loss of use of one arm or one leg	80%
Loss of use of thumb and index finger on the same hand	33%
Loss of use of one hand or one foot	75%
Loss of thumb and index finger on the same hand	33%
Loss of entire sight of both eyes	100%
Loss of speech and loss of hearing in both ears	100%
Loss of entire sight of one eye	75%
Loss of speech	75%
Loss of hearing in both ears	75%
Loss of hearing in one ear	33%
Quadriplegia**	200%
Paraplegia**	200%

Hemiplegia**	200%

**Subject to a maximum of $1,000,000 per person.

If an employee or spouse has multiple losses as a result of one accident, the maximum amount payable shall not exceed 100% of the loss of life benefit amount with the exception of loss of use of both arms, both legs or a combination of one arm and a leg, quadriplegia, paraplegia and hemiplegia. In no event will the maximum benefit amount exceed 200%.

ENHANCED CHILD BENEFIT

Table of Losses

Loss of life	100%
Loss of both arms or both legs	100%
Loss of both hands or both feet	400%
Loss of one hand and one foot	400%
Loss of one hand or one foot, and entire sight of one eye	400%
Loss of one arm or one leg	200%
Loss of one hand or one foot	200%
Loss of four fingers on the same hand	33 1/3%
Loss of all toes on the one foot	50%
Loss of use of both arms or both legs or combination of one arm and one leg**	400%
Loss of use of both hands or both feet or a combination of one hand and one foot	400%
Loss of use of one arm or one leg	200%
Loss of use of thumb and index finger on the same hand	50%
Loss of use of one hand or one foot	150%
Loss of thumb and index finger on the same hand	33 1/3%
Loss of entire sight of both eyes	400%
Loss of speech and loss of hearing in both ears	400%
Loss of entire sight of one eye	200%
Loss of speech	100%
Loss of hearing in both ears	100%
Loss of hearing in one ear	25%
Quadriplegia	400%
Paraplegia	400%
Hemiplegia	400%

Quadriplegia, paraplegia and hemiplegia will become payable after the elimination period of 365 days has been satisfied.

Application Information

Premiums are deducted from your payroll and are based on the amount of the Principal Sum elected. Please refer to the cost table for more information.

To Apply:

1. Select the amount, which best fits your needs from the Benefits and Monthly Cost Table.
2. Complete the application. Be sure to indicate the amount of insurance you require.
3. Return it to your Area Human Resources Office.

Effective Date of Coverage

Your coverage will start on the latest of the following dates:

1. Your coverage will take effect on the effective date of this program or
2. After the effective date of this program, on the 1st of the month following the date your completed Enrolment Form is received by your employer.

Termination of Coverage

Your insurance coverage stops on the earliest of the following dates:

a) On the date this program is terminated;
b) On the premium due date, if your employer fails to pay the insurer your premium, except as the result of an inadvertent error;
c) On the premium due date next following the date you give notice of cancellation to your employer;
d) On the premium due date next following the date you reach 80 years of age;
e) On the premium due date next following the date you cease to be an eligible employee;
f) On the premium due date next following the date you cease to be an active employee on account of leave-of-absence, lay-off, work stoppage, maternity leave, disability, resignation, dismissal, pension or retirement except as provided under the following provisions entitled:
Waiver of Premium
Continuation of Coverage During Approved Leaves
Extension of Coverage

The insurance coverage for your insured spouse and/or dependent children stops on the earlier of:

a) The date such person ceases to be an eligible dependent;
b) The date your insurance is terminated.

Increase, Decrease or Cancellation of Coverage

You may increase or decrease your coverage by completing a new enrolment form. Increasing or decreasing your coverage may only take place once a year on July 1st. Coverage can be cancelled

EXCLUSIONS

A benefit is not paid for a loss which is due to or results from:

- self-inflicted injuries by firearm or otherwise, attempted suicide or suicide (while sane or insane).
- drug overdose.
- carbon monoxide inhalation.
- flying in, entering, or exiting any aircraft owned, leased or operated by the employer or any aircraft owned, leased or operated by an employee of the employer on behalf of the employer. This exclusion does not apply to aircraft chartered with pilot or crew on a one time charter basis.
- flying in, entering, or exiting any aircraft while acting or training as a pilot or crew member. This exclusion does not apply to passengers who temporarily perform pilot or crew functions in a life threatening emergency.
- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion
- full-time service in the armed forces of any country. 8. commission or attempted commission of a criminal offence
- disease or illness.
- loss caused by or resulting from an insured person's emotional trauma, mental or physical illness, disease, pregnancy, childbirth or miscarriage, bacterial or viral infection or bodily malfunction.

This exclusion does not apply to loss resulting from an insured person's bacterial infection caused by an accident or from accidental consumption of a substance contaminated by bacteria.

Accidental Death and Dismemberment Monthly Rates

Principle Sum	Employee Only	Employee and Family
$10,000.00	$0.14	$0.22
$20,000.00	$0.28	$0.44
$30,000.00	$0.42	$0.66
$40,000.00	$0.56	$0.88
$50,000.00	$0.70	$1.10
$60,000.00	$0.84	$1.32
$70,000.00	$0.98	$1.54
$80,000.00	$1.12	$1.76
$90,000.00	$1.26	$1.98
$100,000.00	$1.40	$2.20
$110,000.00	$1.54	$2.42
$120,000.00	$1.68	$2.64
$130,000.00	$1.82	$2.86
$140,000.00	$1.96	$3.08
$150,000.00	$2.10	$3.30
$160,000.00	$2.24	$3.52
$170,000.00	$2.38	$3.74
$180,000.00	$2.52	$3.96
$190,000.00	$2.66	$4.18
$200,000.00	$2.80	$4.40
$210,000.00	$2.94	$4.62
$220,000.00	$3.08	$4.84
$230,000.00	$3.22	$5.06
$240,000.00	$3.36	$5.28
$250,000.00	$3.50	$5.50

Principle Sum	Employee Only	Employee and Family
$260,000.00	$3.64	$5.72
$270,000.00	$3.78	$5.94
$280,000.00	$3.92	$6.16
$290,000.00	$4.06	$6.38
$300,000.00	$4.20	$6.60
$310,000.00	$4.34	$6.82
$320,000.00	$4.48	$7.04
$330,000.00	$4.62	$7.26
$340,000.00	$4.76	$7.48
$350,000.00	$4.90	$7.70
$360,000.00	$5.04	$7.92
$370,000.00	$5.18	$8.14
$380,000.00	$5.32	$8.36
$390,000.00	$5.46	$8.58
$400,000.00	$5.60	$8.80
$410,000.00	$5.74	$9.02
$420,000.00	$5.88	$9.24
$430,000.00	$6.02	$9.46
$440,000.00	$6.16	$9.68
$450,000.00	$6.30	$9.90
$460,000.00	$6.44	$10.12
$470,000.00	$6.58	$10.34
$480,000.00	$6.72	$10.56
$490,000.00	$6.86	$10.78
$500,000.00	$7.00	$11.00