APPLICATION FORM

2I“FH 8VH 2QO\

(OLJLELOLW\ FRQ“UPHG

Effective date of coverage

*HQHUDO ,QIRUPDWLRQ DQG 3ULRU &RYHUDJH &RQ“UPDWLRQ

Applicant's Last Name _____ First Name _____ Initial _____

Address _____

City _____ Province _____ Postal Code _____

Phone (_____) _____ Email Address _____

Language of preference: R English R French

To be eligible, individuals must have been recognized as an owner, principal or executive, and actively at work at time of retirement.

3OHDVH LQGLFDWH WKH FXUUHQW SUHYLRXV &KDPEHUV 3ODQ 0D[LPXP %HQH“W

Firm Name _____

Firm # _____ &HUWL“FDWH _____ Date coverage ended (YYYY/MM/DD) _____

3OHDVH SURYLGH FRQWDFW LQIRUPDWLRQ IURP \RXU SUHYLRXV &KDPEHUV 3ODQ verify your eligibility:

Name _____ Phone (_____) _____

Title _____ Email Address _____

Plan Choice

I apply for Retiree coverage of:

RPlan A with (select one)	RDrug Option	R No Drugs
RPlan B with (select one)	RDrug Option	R No Drugs
RPlan C with (select one)	RDrug Option	R No Drugs