MSH INTERNATIONAL
SIACI SAINT HONORE GROUP

APPLICATION FOR INTERNATIONAL BENEFITS

Company
GCCL (Cayman) Ocean Fleet Management Ltd.

TO BE COMPLETED BY PLAN ADMINISTRATOR

Employee Surname	Employee Given Name	Initials

Date of Foreign Assignment (MM/DD/YYYY)	**Occupation**
Effective Date of Employee Coverage	**Annual Income (please indicate currency)**
Comments or Additional Information Please provide any additional information that may assist in processing this application.	

TO BE COMPLETED BY EMPLOYEE

Date of Birth (MM/DD/YYYY)	**Gender** Male ☐ Female ☐	**SIN/SSN/Employer ID**
Address		
City/Province/State	**Postal Code/Zip Code**	
Are you a resident of Alberta, Canada? ☐ Yes ☐ No	**Email**	
Business Phone *(optional)*	**Residence Phone *(optional)***	
Home Country (Passport under which you travel)	**Host Country (Country of Foreign Assignment)**	

BENEFICIARY & CONTINGENT BENEFICIARY DESIGNATION

Name of Beneficiary(ies)	Relationship	Address	Percentage
Name of Contingent Beneficiary(ies)	**Relationship**	**Address**	**Percentage**

The Contingent beneficiary would become the primary beneficiary automatically in the event that the primary beneficiary or all of the primary beneficiaries are deceased prior to the AD&D claim of the primary insured.

I hereby appoint the following trustee to receive and to hold in trust, on behalf of any beneficiary, money payable to the beneficiary under this group benefits plan where, at time payment is to be made, the beneficiary is a minor and otherwise lacks legal capacity. If no trustee is appointed, benefits will be payable to the insureds estate.

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Trustee Last Name | First Name | Middle Initial | Relationship to Insured

Privacy: Protecting Your Personal Information
Your employer & the insurers recognize and respect the importance of privacy. When you apply for coverage, the insurers establish a confidential file that is kept in the offices of the insurers or the offices of an organization authorized by the insurers. We limit access to information in your file to insurer staff or persons authorized by your employer and/or the insurers who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use this information to determine your eligibility for coverage and to administer the group benefits plan.

Authorizations and Declarations

- I hereby apply for coverage under the group benefits plan issued by the insurers.
- I authorize:
  - my employer to deduct from my pay and remit the plan member contribution required under the group benefits plan, if applicable;
  - The insurers, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with the insurers to exchange personal information, when nessecary to determine my eligibility for coverage and to administer the group benefit plan.
- If applying for coverage for my spouse and/or dependents, I confirm that I am authorized to act on their behalf.
- I agree that a photocopy or electronic copy of this Authorizations and Declarations Section is as valid as the original.
- I certify that the information given is true, correct and complete to the best of my knowledge.
- I recognize that I may be required to disclose any treatment (including prescribed medicines) received prior to the effective date of my coverage.

Insured Signature	**Date**
Please forward completed forms to: MSH INTERNATIONAL Suite 300, 999 – 8th Street S.W. Calgary, Alberta, Canada T2R 1N7	**MSH INTERNATIONAL (CANADA) LTD. USE ONLY** **Policy No.** L61410668

Incomplete applications may delay the processing of your enrollment, which may affect your coverage effective date.