ACADIA UNIVERSITY | HUMAN RESOURCES

Employee Information			
Employee Name (Last, First, Initial)			
Mailing Address:			
P.O. Box/Street			
Town/Province/PC			
Telephone Number			
Social Insurance Number		Employee Number	
Date of Birth (YYMMDD)		Gender	Male ☐ Female ☐
Department		Date Employed (YY/MM/DD)	
Position:			

Beneficiary Designation (*Basic Group Life / Accidental Death & Dismemberment*)			
Name(Last, First, Initial)	Relationship	Percentage	Date of Birth (YYMMDD)

I hereby authorize any required payroll deduction for group insurance benefits under my employer's program and consent to the use of my Social Insurance Number (S.I.N.) for record-keeping and file identification purposes. I reserve the right to change my beneficiary(ies) designation at any time.

Employee's Signature ______________________ Date ______________________

To be completed by Employer			
Class of Coverage – Health		Date Employed (YYMMDD)	
Completed by (Signature)		Date	

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