Human Resources
Henry Hicks Academic Administration Building
Room 21 – 6299 South Street
Halifax, NS B3H 4R2

DALHOUSIE UNIVERSITY

Voluntary Personal Accident

☐ New Application
☐ Change to Coverage
☐ Termination of Coverage

Employee Name:	Employee Number:
Date of Birth (dd/mm/yy):	

Coverage Requested

Amount	_____

Family Coverage	☐
Single Coverage	☐

Dependant Information

	Full Name of Insured	Date of Birth	Remove or Add
Spouse			
Dependant			

Termination of Coverage

Termination of Family Coverage	☐
Termination of Single Coverage	☐

Beneficiary Information

Name	Date of Birth	Relationship

I certify that all information contained hereon is correct and hereby authorize payroll deductions, if required.

_____ Employee Signature

_____ Date