Beneplan Inc

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Group Benefits **ENROLLMENT FORM - ADM1 2013**

Employee

Employer	Division	Class	Certificate

Last Name	First Name

Street Address	City	Province	Postal Code

Birth date (yyyy/mm/dd)	Hire date (yyyy/mm/dd)	Effective date (yyyy/mm/dd)	Gender ❒ Male ❒ Female	Language ❒ English ❒ French

Occupation	Earnings ($)
	❒ Hour (hours per week ____) ❒ Week ❒ Month ❒ Year

Spouse/Common Law Partner

Last Name	First Name	Birth date (yyyy/mm/dd)	Gender ❒ Male ❒ Female

If common law, cohabitation started on (yyyy/mm/dd) _____

→ Group Benefits Enrollment form

All dependants must listed on the form, even if you are opting out of health and dental benefits.

Children

Last Name	First Name	Birth date (yyyy/mm/dd)	Gender ❒ Male ❒ Female
			Gender ❒ Male ❒ Female
			Gender ❒ Male ❒ Female
			Gender ❒ Male ❒ Female

Note: Children, age 21 to 24 must be full-time students to have coverage. Please complete "Student Eligibility" form. ❒ Please indicate if your child is disabled.

Beneficiary designation

Last Name	First Name	Relationship

Note: I appoint as revocable beneficiary of all insurance payable in the event of my death.

You must add trustee information for a beneficiary less than 19 years of age. Name _____

Coverage

Extended Health Care	❒ Single	❒ Family ❒ COB* for spouse only ❒ COB* for all dependants *Name of Insurer and Policy #: _____	❒ Opt Out of coverage DISCLAIMER: I understand that I am opting out of benefits. I understand that to rejoin unconditionally I must do so within 30 days of losing coverage, otherwise I will be required to provide evidence of satisfactory health and be subjected to approval.
Dental Care	❒ Single	❒ Family ❒ COB* for spouse only ❒ COB* for all dependants *Name of Insurer and Policy #: _____	❒ Opt Out of coverage DISCLAIMER: I understand that I am opting out of benefits. I understand that to rejoin unconditionally I must do so within 30 days of losing coverage, otherwise I will be required to provide evidence of satisfactory health and be subjected to approval.

Declaration

I hereby apply for group benefits coverage and authorize the deduction of my pay of any contributions required under the group benefits plan. I hereby authorize my employer and/or gropu plan administrator and/or insurance carrier(s) and/or their agent(s) and/or any other person and/or organization having any relevant information regarding me and/or my spouse and/or my dependant(s) to release and exchange any and all information necessary for the purposes of determining eligibility for benefits and administration of the group benefits plan. I confirm I am authorized to act on behalf of my spouse and/or dependant(s) for such purposes. I authorize the use of my social insurance number (SIN) for the purpose of tax reporting. I declare that the information provided here is true, complete and accurate. A copy of this authorization shall be considered as valid as the original.

Employee signature **Dated (yyyy/mm/dd)**

Employer signature **Dated (yyyy/mm/dd)**