beneplan

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Group Benefits ENROLLMENT Form

Employee

Employer:		Division:	Class:	Certificate:	
Last name:	First name:			Gender: ☐ Male ☐ Female	Language: ☐ English ☐ French
Birth date: (yyyy/mm/dd)	Hire date: (yyyy/mm/dd)	Effective date: (yyyy/mm/dd)		Coverage: ☐ Single ☐ Family ☐ Opt out	
Occupation:		Earnings: $ ☐ Hour (hours per week ______) ☐ Week ☐ Month ☐ Year			
Street address:					
City:		Province:		Postal Code:	

Spouse / Common Law

Last name:	First name:	Birth date: (yyyy/mm/dd)	Gender: ☐ Male ☐ Female

Note: If common law, cohabitation started on: (yyyy/mm/dd) _____ / __ / __.

Children

Last name:	First name:	Birth date: (yyyy/mm/dd)	Gender:	
			☐ Male ☐ Female	☐ Student age 21-24 ☐ Handicapped
			☐ Male ☐ Female	☐ Student age 21-24 ☐ Handicapped
			☐ Male ☐ Female	☐ Student age 21-24 ☐ Handicapped
			☐ Male ☐ Female	☐ Student age 21-24 ☐ Handicapped

Note: Children, age 21 to 24 must be full-time students to have coverage. Please complete "Student Eligibility" form.

Beneficiary

Last name:	First name:	Relationship:

Note: I appoint as revocable beneficiary of all insurance payable in the event of my death. In the event that the named is a minor, I hereby appoint as trustee: (name) ________________________________, (relationship to employee) ____________________.

Opt Out

I hereby opt out of the benefits below because I already have coverage through my spouse. I understand that I may rejoin if my spouse loses his/her coverage. I further 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.

☐ Health
☐ Dental

Spouse's insurance company and policy:

Co-ordination of Benefits (COB)

I have chosen family coverage and my spouse has coverage through his/her employer and have indicated the type of coverage that applies.

☐ Health for spouse only
☐ Dental for spouse only
☐ Health for spouse and dependant(s)
☐ Dental for spouse and dependant(s)

Spouse's insurance company and policy:

Declaration

I hereby apply for group benefits coverage and authorize the deduction from my pay of any contributions required under the group benefits plan. I hereby authorize my employer and/or group 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 dependent(s) for such purposes. I authorize the use of my social insurance number (SIN) for the purposes 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)