



Group Benefits Enrollment Form

Cost Centre:

Employee

Employer:		Division:	Class:	Certificate:
Last name:		First name:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> English <input type="checkbox"/> Female <input type="checkbox"/> French
Birth date: (yyyy/mm/dd)	Hire date: (yyyy/mm/dd)	Effective date: (yyyy/mm/dd)		Coverage: <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Opt out
Occupation:			Earnings: \$ <input type="checkbox"/> Hour (hours per week _____) <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	
Street address:				
City:		Province:	Postal Code:	

Spouse / Common Law

Last name:	First name:	Birth date: (yyyy/mm/dd)	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
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Note: If common law, cohabitation started on: (yyyy/mm/dd) ____ / __ / __.

Children

Last name:	First name:	Birth date: (yyyy/mm/dd)	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Student age 21-24 <input type="checkbox"/> Female <input type="checkbox"/> Handicapped
			<input type="checkbox"/> Male <input type="checkbox"/> Student age 21-24 <input type="checkbox"/> Female <input type="checkbox"/> Handicapped
			<input type="checkbox"/> Male <input type="checkbox"/> Student age 21-24 <input type="checkbox"/> Female <input type="checkbox"/> Handicapped
			<input type="checkbox"/> Male <input type="checkbox"/> Student age 21-24 <input type="checkbox"/> Female <input type="checkbox"/> 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:	% Percent:
Last Name:	First Name:	Relationship	% Percent:
Last name:	First name:	Relationship:	% Percent:
Last Name:	First Name:	Relationship	% Percent:

Note: Beneficiary percentage can be split in any manner between listed beneficiaries, but the total must equal 100%.

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 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:

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)