OUR PEOPLE

NON UNION - INTERNS

Flex Group Benefits Information Form

☑ New Employee ☐ Add/Delete Dependents ☐ Change of Name

☐ Change of Address ☐ Change of Coverage ☐ Other _____

Employee Information

Status: Intern ☑

Employee Name (Last/ First/ Initial) _____

Employee Number _____ **Sex** _____ **Birthdate** _____ *(dd/mm/yy)*

_____

Street Address **Apt. No.** **Province** **Postal Code**

_____

Home Telephone **Other Telephone** **Email Address**

Dependent Info

	Full Name	Sex at Birth	Birthdate (d/m/y)	Status if Over Age 21
Spouse				
Children				

Co-ordination of Benefits

Are you and/or your spouse and children covered under another group plan? ☐ Yes ☑ No

If yes, Insurance Company Name _____

Policy No. _____ **ID No.** _____

Is the other coverage Single or Family? ☐ Single ☐ Family

Is the other coverage for Health/Dental or both? ☐ Health Only ☐ Dental Only ☐ Both Health and Dental

I hereby apply for group insurance benefits and authorize any required payroll deductions. I reserve the right to change my beneficiary designations at any time. My beneficiary designation is revocable (including spouse) and replaces the previous revocable beneficiary.

Employee Signature _____ **Date Signed** _____

For Administrative Use Only

Policy # Health and Dental_____ HRM Administrator_____ Date_____