

Group Benefits Information Form

New Employee
 Add/Delete Dependents
 Change of Name
 Change of Address
 Change of Coverage
 Other _____

Employee Information

Status:
 Full Time
 Contract
 Part Time
 Retiree

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

Required Health Coverage
 Single
 Family

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

Dependent Life Insurance *(\$5,000 spouse and \$2,000 each dependent child)*

Yes, I have a spouse or dependent child. Note: coverage is mandatory if you have a spouse and/or dependent child.

No, I do not have a spouse or dependent child.

Beneficiary Designation

This section is to designate beneficiaries to receive your benefits under your Life Insurance and your Accidental Death & Dismemberment policies.

| Beneficiary Name | Sex | Relationship to Employee | Percentage Share <small>(must total 100%)</small> |
|------------------|-----|--------------------------|--|
| _____ | | | |
| _____ | | | |
| _____ | | | |
| _____ | | | |

Contact Information of Beneficiary _____

Name of Trustee (required if beneficiary is under age 18) _____

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 _____