CUPE LOCAL 108

Group Benefits Information Form

OUR PEOPLE

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

☐ Change of Address ☐ Change of Coverage ☐ Other ______________

Employee Information

Status: ☐ Full Time ☐ Contract ☐ Part Time ☐ Seasonal

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

Required Dental Coverage ☐ Single ☐ Family

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

Name of the Person Insured: ______________________________

Dependent Info

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

Dependent Life Insurance *($6,000 spouse and $3,000 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.**

Voluntary Optional Coverage

Please refer to the Voluntary Optional Coverage sheet for specific details

Optional Life Insurance

☐ Optional Life - Employee Only Additional Coverage _______ units x $10,000

☐ Optional Life - Spouse Only Additional Coverage _______ units x $10,000

Optional Accidental Death & Dismemberment

☐ Optional AD&D - Employee Only Additional Coverage _______ units x $10,000

☐ Optional AD&D - Employee & Family Additional Coverage _______ units x $10,000

Complete the following section to appoint a beneficiary for any benefits payable on your death.

Beneficiary Name	Sex	Relationship to Employee	Percentage Share *(must total 100%)*

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** ______________________

For Administrative Use Only

Policy # Health and Dental________________ HRM Administrator_______________ Date___________