HALIFAX REGIONAL MUNICIPALITY



Flex Group Benefits Information Form

New Employee Add/Delete Dependents Change of Name Change of Address Change of Coverage Other							
	Information						
Status:	Full 1	Time	Coi	ntract	Part Time	Retiree	
Employee Name (Last/ First/ Initial)							
Employee N	Number			Sex	Birthda	te	
Street Address Apt. No.			Province Po		Code		
Home Telephone Other Telephone Email Address							
Dependent Info							
F	ull 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
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
Contact Information of Beneficiary
Name of Trustee (required if beneficiary is under age 18)
hereby apply for group insurance benefits and authorize any required payroll deductions. 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