NSGEU 222 - INTERNS

OUR PEOPLE

Group Benefit Enrolment 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**

Required Health Coverage

- [ ] Single
- [ ] Family
- [ ] No coverage

* Health Coverage is mandatory if you do not have another medical plan

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

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**______________________________

Ink signature required for beneficiary updates.