HALIFAX REGIONAL MUNICIPALITY

OUR PEOPLE

Flex 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**

Dependent Info

	Full Name	Sex	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 *(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** _____

An INK signature required for new enrollments and beneficiary updates.

For Administrative Use Only

Policy # Health and Dental_____ HRM Administrator_____ Date_____