

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 ☐ Seasonal

Employee Name (Last/ First/ Initial) _____

Employee Number _____ Sex _____ Birthdate _____
(dd/mm/yy)

Street Address Apt. No. City / Town Province

Postal Code 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	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 _____

An INK signature is required for new enrolments and beneficiary updates.