ATU – TRADITIONAL PLAN

OUR PEOPLE

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

Required Health Coverage

☑ Single ☐ Family

Dependent Info

	Full 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

Dependent Life Insurance *($5,000 spouse and $2,000 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.**

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** _____