CUPE LOCAL 108

Group Benefits Information Form

OUR PEOPLE

☐ 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.** **Province** **Postal Code**

_____

Home Telephone **Other 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 at Birth	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** _____

For Administrative Use Only

Policy # Health and Dental_____ HRM Administrator_____ Date_____