

Group Benefits Enrolment 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

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

Single Family No Coverage

Optional Dental Coverage

Single Family No Coverage

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 *(\$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.**

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 <small>(must total 100%)</small>

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 _____