NSUPE 13 - INTERNS

OUR PEOPLE

Group Benefit Enrolment Form

☑ New Employee ☐ Add/Delete Dependents ☐ Change of Name

☐ Change of Address ☐ Change of Coverage ☐ Other _____

Employee Information

Status: Intern ☑

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 ☑ No coverage

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

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 Info				
	Full Name	**Sex at Birth**	**Birthdate (d/m/y)**	**Status if Over Age 21**
Spouse				
Children				

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**_____