MEMBER APPLICATION - GROUP BENEFITS ENROLMENT

PLEASE PRINT LEGIBLY

☐ ENGLISH DOCUMENTATION ☐ FRENCH DOCUMENTATION

MEMBER SECTION

1

MEMBER FIRST NAME	MEMBER LAST NAME		
MEMBER ADDRESS	CITY	PROVINCE	POSTAL CODE
DATE OF BIRTH yyyy/mm/dd	GENDER	PROVINCIAL HEALTH CARE NO. (BC RESIDENTS ONLY)	
WORK EMAIL	PERSONAL EMAIL	PERSONAL PHONE #	

ARE YOU MARRIED OR IN A COMMON LAW RELATIONSHIP? ☐ YES ☐ NO — IF COMMON LAW, PLEASE PROVIDE DATE OF COHABITATION (yyyy/mm/dd)

LIST OF DEPENDENTS (Spouse, then dependents, oldest first)

FIRST NAME	LAST NAME	GENDER	DATE OF BIRTH yyyy/mm/dd	RELATIONSHIP	PROV HEALTH CARE# (BC RESIDENTS ONLY)

3 BENEFICIARY DESIGNATION - GROUP LIFE, BASIC AD&D/ASI AND LONG TERM DISABILITY SURVIVOR BENEFITS (IF APPLICABLE)

If no beneficiary is designated by the member, the benefit is payable to the estate. Percentages must total 100% to be valid.

NAME OF BENEFICIARY	RELATIONSHIP TO MEMBER	% OF BENEFIT	DATE OF BIRTH yyyy/mm/dd

FOR QUEBEC RESIDENTS ONLY: In Quebec, the designation of your spouse as beneficiary is irrevocable unless otherwise specified. If beneficiary is shown as irrevocable, his/her consent is required to change it.

QUEBEC RESIDENTS ONLY:
IF THE SPOUSE IS DESIGNATED AS BENEFICIARY, THIS DESIGNATION IS:
☐ REVOCABLE ☐ IRREVOCABLE

4 **DECLARATION APPOINTING TRUSTEE (Complete if Beneficiary is under the age of majority)** *NOT APPLICABLE IN QUEBEC*

I hereby appoint _____ as Trustee to receive any amount due to any Beneficiary(ies) under the age of majority and declare the receipt of such Trustee shall be good discharge to The Group Insurer(s) for the amount so paid. And I do hereby authorize such Trustee, at his/her discretion, to expend all or any portion of such amount and/or the income there from for the maintenance or education of such beneficiary(ies).

Address of Trustee: _____ Relationship to Beneficiary: _____

5 **PLEASE INDICATE YOUR DESIRED COVERAGE LEVEL (ALL FUTURE CHANGES SHOULD BE REPORTED TO YOUR PLAN ADMINISTRATOR)**

Extended Health Care (EHC) _____ (S/C/F/O) Dental Care: _____ (S/C/F/O)

S = Self Only (Single) C= Self and One Dependent (Couple) F = Self and Two or More Dependents (Family) O = No coverage for myself or my Dependents

Note: You must have alternative insurance to opt out of these benefit coverages. Please complete Waiver section below.

6 **WAIVER OF EXTENDED HEALTH AND/OR DENTAL COVERAGE**

I understand the plan of Group Insurance offered to me. However, if permitted by the provisions of the plan, I wish to waive the following benefits. I recognize that if my alternate coverage terminates, I must apply for coverage under my employer's Group Plan within 31 days of the termination date. Should I fail to do so, I may be required to submit, at my own expense, satisfactory evidence of insurability for myself and my dependents, or I may be required to pay premiums retroactive to the date of eligibility or benefits may be restricted or denied.

☐ Extended Health For: ☐ Myself ☐ My Dependents ☐ Dental Care: For: ☐ Myself ☐ My Dependents

☐ **I confirm that I have comparable coverage provided for me and/or my dependents under the following benefits plan:**

Name of Employer: _____ Name of Insurer: _____ Group Number: _____

7 **CO-ORDINATION OF BENEFITS** ARE YOU OR YOUR DEPENDENTS COVERED UNDER ANOTHER BENEFITS PLAN?

Extended Health Care (EHC) _____ (Y/N) Coverage Level _____ (S/C/F) Dental Care: _____ (Y/N) Coverage Level _____ (S/C/F)

8 **MEMBER AUTHORIZATION - PLEASE READ, SIGN AND DATE**

I hereby apply for group benefits coverage provided by my employer and authorize the regular deduction from my pay for any contributions to be made by me in relation to benefits.
In regard to these and other benefits for which I am applying or will apply, I am providing certain personal information about myself and my family (if appropriate) and I hereby expressly provide consent to my employer, and to GroupHEALTH Global Benefit Systems Inc. (GroupHEALTH Benefit Solutions®), the plan insurers and re-insurers, providers and agents to collect, use, and disclose any and all information necessary to establish and maintain my benefits. I also understand that GroupHEALTH Benefit Solutions® will acquire information about me and my family in the course of, but not limited to, the provisions of benefits and satisfying any claims made and responding to insurer or provider requests. I expressly provide consent that GroupHEALTH Benefit Solutions® may disclose such information and all other information to the plan insurers and re-insureres, providers, agents, the employer or anyone necessary for the provision of benefits, in order to respond to insurer or provider requests for the purpose of determining eligibility, administration of benefits in good standing. I understand that no personal information will be disclosed for any other purpose without my consent. GroupHEALTH Benefit Solutions® limits access to those that are required to review the information for the establishment and provision of benefits. I confirm that I am authorized to act on behalf of my spouse and/or dependents for the purposes as set out herein. I declare the information provided with this application is true, complete and accurate. Any copy of this authorization is as valid as the original.

MEMBER SIGNATURE X DATE X

EMPLOYER SECTION

9 EMPLOYER NAME

PERSONAL IDENTIFICATION NUMBER		MEMBER NUMBER		OCCUPATION		
DATE OF PART-TIME EMPLOYMENT	DATE OF FULL-TIME EMPLOYMENT	DATE ELIGIBLE FOR COVERAGE	ANNUAL EARNINGS	# OF HOURS PER WEEK/F.T.	CLASS	DEPT/DIV/ LOCATION