

Group Plus Enrolment Form



PLEASE NOTE: Employee Enrolment Form must be completed in full by each employee – This is used to produce Benefit Cards.

Date: _____ Class: _____ Division: _____

Part 1 – Employer Information

Employer			
Address	City	Province	Postal Code
Phone Number	Fax Number	Email	

Part 2 – Employee Information

Name of Employee	SIN Number
Address	City Province Postal Code
Phone Number	Email
Date of Birth (MM/DD/YYYY)	Sex (M/F)
Date of Hire (MM/DD/YYYY)	Coverage Effective Date of Coverage (MM/DD/YYYY)

Part 3 – Dependent Information

Spouse Name	Sex (M/F)	Date of Birth (MM/DD/YYYY)
Child 1 Name	Sex (M/F)	Date of Birth (MM/DD/YYYY)
Child 2 Name	Sex (M/F)	Date of Birth (MM/DD/YYYY)
Child 3 Name	Sex (M/F)	Date of Birth (MM/DD/YYYY)
Child 4 Name	Sex (M/F)	Date of Birth (MM/DD/YYYY)

Part 4 – Spousal Coverage (if applicable)

Is your spouse covered for Health Benefits by his/her employer? No Yes –Indicate Single Family

Is your spouse covered for Dental Benefits by his/her employer? No Yes –Indicate Single Family

Part 5 – Refusals (If you do not choose coordination of benefits with your spouse's plan)

I refuse insurance on: My dependents under Health Benefits Dental Benefits

Myself and my dependents under Health Benefits Dental Benefits

If refusing benefits, you must provide name of present insurer: _____ Policy # _____

Employee Signature: _____ Employer Signature: _____



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FORM H.