

# Group Benefit Enrolment Form

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## Purpose of Group Enrolment Form

The purpose of the group enrolment form for group insurance is to provide necessary information to obtain coverage and written confirmation that you wish to obtain coverage under the policyholder.

All sections must be completed.  
 Incomplete forms will be returned.  
 Please Print in Ink.

Employee Name	Last:			First:		
Residence	Street:			Apt #	City:	
	Prov:			Postal:		
Date of Birth (MM/DD/YY)	Language Preference		<input type="checkbox"/> English	<input type="checkbox"/> French	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
E-Mail Address				Phone No.		
Marital Status			Required Coverage		Health	Dental
<input type="checkbox"/> Single		<input type="checkbox"/> Separated		My Self Only	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Married		<input type="checkbox"/> Divorced		Self & Dependents	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Common Law		<input type="checkbox"/> Widowed		Waived*	<input type="checkbox"/>	<input type="checkbox"/>
Dependent Life (if applicable)	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Critical Illness	Single <input type="checkbox"/>	Family <input type="checkbox"/>
				Do you have provincial health coverage?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

\*If your spouse has other coverage and you wish to waive Extended Health and Dental, the following information is required:

Name of Insuring Company			Policy #		
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## Co-Ordination of Benefits

Spouse Last Name:			Spouse First Name:		
Does your Spouse have health care coverage?			Does your Spouse have dental coverage?		
<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, type of coverage:	<input type="checkbox"/> Single	<input type="checkbox"/> Family	If yes, type of coverage:	<input type="checkbox"/> Single	<input type="checkbox"/> Family

When enrolling for family benefits, coverage for dependents will only be provided if the information below is complete:

Dependent Name (Including name of Spouse) First and Last (Please Print Clearly)	Gender M or F	Relationship to Insured	Date of Birth MM/DD/YY	✓ Below if There is Other Coverage		If Dependent Child is Over the Age of 21 are They a Full-Time Student?	
				Health	Dental	Yes	No
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

~ Beneficiary Designation ~

Unless otherwise designated, the beneficiary is "Revocable". If no beneficiary is designated, the beneficiary will be the Estate. If naming a minor as a Beneficiary, please appoint one in the section below. Without completion of this section, the insurer may hold proceeds until the minor reaches age of majority. For Province of Quebec Residents, the appointment of a spouse as beneficiary is considered "Irrevocable" unless the wording "Revocable" is actually selected after the spouse's name. If you are a resident of Quebec please indicate Revocable or Irrevocable.

Full First and Last Name of Beneficiary (ies)	Percentage	Relationship to Insured	Date of Birth	Revocable	Irrevocable
	%			<input type="checkbox"/>	<input type="checkbox"/>
	%			<input type="checkbox"/>	<input type="checkbox"/>
	%			<input type="checkbox"/>	<input type="checkbox"/>

Note: Percentages must total 100% to be valid.

I appoint \_\_\_\_\_ as **Trustee** to receive any payment payable to a minor beneficiary under this policy. The trustee shall discharge the Insurer for the amount paid. I authorize the "Trustee" to spend all or part of the amount, or interest earned on it, for the support or education of the minor.  
 Note: Trustee appointment is not available in the Province of Quebec.

\_\_\_\_\_

Signature of Participant

\_\_\_\_\_

Signature of Witness

\_\_\_\_\_

Date Signed  
(MM/DD/YYYY)

~ Declaration and Authorization for the Collection and Communication of Personal Information to Third Parties ~

I authorize Adminplex Resource Services Inc. and affiliated companies, strictly for the purposes of providing group insurance to collect from me and my employer only information deemed necessary to provide group insurance and communicate the said information only to organizations deemed necessary to provide and process my group insurance. I am applying for insurance coverage in accordance with the provisions and conditions of the Group Insurance Contract issued at the Policyholder's request. I authorize the policyholder to deduct from my earnings (if applicable) the required contribution for the insurance to which I am or may be entitled

\_\_\_\_\_

**\*\*\* Signature of Participant \*\*\***

\_\_\_\_\_

**\*\*\* Date Signed (MM/DD/YYYY) \*\*\***

**To Be Completed by Plan Administrator**

Policy No.	Policy Name					
Payroll No.	Class	Department Code				
Salary	Salary Basis	<input type="checkbox"/> Annual	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Hourly
No. of Hours Worked per Week	Occupation					
Date of Hire (MM/DD/YY)	Date of Full-Time Employment (MM/DD/YY)	Date Waiting Period Completed (MM/DD/YY)				

\_\_\_\_\_

**\*\*\* Signature of Plan Administrator \*\*\***

\_\_\_\_\_

**\*\*\* Date Signed (MM/DD/YY) \*\*\***