

Group Benefit Enrollment

30 Kelfield St., Toronto, ON M9W 5A2

1.800.565.2467



Purpose of Group Enrollment Form

The purpose of the group enrollment 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 Code: _____

Date of Birth (MM/DD/YY) _____ Language Preference English French Gender Male Female

E-Mail Address _____ Phone No. _____

Marital Status Single Separated Married Divorced Common Law Widowed

Required Coverage Health Dental
 My Self Only
 My Self & Dependents
 Waived*

*Coverage will be waived only if there is coverage elsewhere and the following information is supplied:

Name of Insuring Company _____ Policy # _____

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

Dependent Name 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	Revocable	Irrevocable
	%		<input type="checkbox"/>	<input type="checkbox"/>
	%		<input type="checkbox"/>	<input type="checkbox"/>
	%		<input type="checkbox"/>	<input type="checkbox"/>

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.

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 Employer

Policy No. _____ Policy Name _____

Payroll No. _____ Class _____) _____

Salary _____ Salary Basis Annual Bi-Weekly Weekly Monthly 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 Employer ***

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