# Group Benefit Enrollment Form

30 Kelfield Street, 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* | ☐ | ☐ |

Do you have provincial health coverage Yes ☐ No ☐

*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 #

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 Health | Dental | If Dependent Child is Over the Age of 21 are They a Full-Time Student? Yes | No |
|---|---|---|---|---|---|---|---|
| | | | | ☐ | ☐ | ☐ | ☐ |
| | | | | ☐ | ☐ | ☐ | ☐ |
| | | | | ☐ | ☐ | ☐ | ☐ |
| | | | | ☐ | ☐ | ☐ | ☐ |
| | | | | ☐ | ☐ | ☐ | ☐ |

## ~ 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 a Trustee 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 |
|---|---|---|---|---|
| | % | | ☐ | ☐ |
| | % | | ☐ | ☐ |
| | % | | ☐ | ☐ |

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 Plan Administrator

Policy No. Policy Name

Payroll No. Class Department Code

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