ENROLMENT FORM
GROUP INSURANCE

◯ New employee ◯ Reinstatement

1 - ADMINISTRATIVE INFORMATION (to be completed by the employer)

EMPLOYER NAME			POLICY NO.	DIVISION	CLASS NO.
				001	1
CERTIFICATE NO. (If known)		OCCUPATION			
HOURS WORKED PER WEEK 20 hours + / week		DATE EMPLOYED ON A FULL-TIME BASIS		INSURANCE ELIGIBILITY DATE	

Details of income	Amount	Indicate if salary amount is hourly, weekly, bi-weekly or annual				
Hourly wage		◯ Hourly				
Salary		◯ Weekly	◯ Bi-weekly	◯ Monthly	◯ Annually	◯ Other:
Bonus		◯ Weekly	◯ Bi-weekly	◯ Monthly	◯ Annually	◯ Other:
Commission		◯ Weekly	◯ Bi-weekly	◯ Monthly	◯ Annually	◯ Other:

Employer's signature	Date signed (MM/DD/YYYY)

2 - EMPLOYEE INFORMATION (To be completed by the employee)

LAST NAME		FIRST NAME	DATE OF BIRTH	
ADDRESS : Number, street, apt.		CITY	PROVINCE	POSTAL CODE
◯ Male ◯ Female	Language Preference :			
EMAIL ADDRESS		PHONE NUMBER	DO YOU HAVE A PROVINCIAL HEALTH CARD?	

Marital Status ◯ Single ◯ Married ◯ Separated ◯ Widow(er) ◯ Divorced ◯ Common Law

If common-law spouse, cohabitation start date (MM/DD/YYYY)

3 - SUPP. HEALTH AND/OR DENTAL CARE COVERAGE

◯ **Individual** (if single go to question 5)

◯ **Family** ◯ **Couple** ◯ **Single parent**
(For family, couple or single parent coverage answer question 3A)

◯ **Waived** (If waived, go to question 3A, 3B, 3C)

3A - DEPENDENT LIFE INSURANCE

With some insurers, dependant life insurance is mandatory for members who have a spouse (or common-law spouse) and /or children. Please check with your plan administrator for further details.

◯ I would like my dependants to receive life insurance coverage (if possible).

3B - SUPPLEMENTARY HEALTH AND/OR DENTAL CARE COVERAGE WAIVER

Supplementary health (Prescription drugs, Paramedical services):
◯ I waive this coverage for myself and my dependants
◯ I waive this coverage only for my dependants

Dental Care
◯ I waive this coverage for myself and my dependants
◯ I waive this coverage only for my dependants

Excerpt from RAMQ's website
Persons who fulfill the eligibility requirements for a private plan must join that plan... If the employer offers a private plan, the employees are required to join that plan, unless they can prove that they are covered by another private plan (another group insurance or employee benefit plan).

Read the full text

3C - OTHER COVERAGE AND COORDINATION OF BENEFITS

Are you or your dependants covered by another plan? ◯ Yes or ◯ No
If so, please provide the following information:
Policy Holder: _____ Insurer: _____
Effective date of coverage (other plan): _____ Policy number: _____
Certificate/Identification number: _____

4 - DEPENDANT INFORMATION

Please list any dependants. If more space is required, attach a separate sheet.

First name	Last name	Relationship	Date of birth (MM/DD/YYYY)	Gender (M/F)	Disabled child	Full time student (Age 21-26)*	Dependant has a provincial health card.
					◯ Yes	◯ Yes	◯ Yes
					◯ Yes	◯ Yes	◯ Yes
					◯ Yes	◯ Yes	◯ Yes
					◯ Yes	◯ Yes	◯ Yes

* May vary by insurance carrier. Please refer to your insurance contract.

5 - BENEFICIARY DESIGNATION

		Date of birth					You **MUST** select one of the following	
Last name	First name	YYYY	MM	DD	Relationship to Employee	%	Revocable	Irrevocable
							◯	◯
							◯	◯
							◯	◯
							◯	◯

REVOCABLE: Means that the beneficiary designation may be changed without the beneficiary's consent.
IRREVOCABLE: Means that the beneficiary designation **CANNOT** be changed without the beneficiary's consent.
The **IRREVOCABLE** designation of a minor **CANNOT** be changed before he reaches the age of majority.

CONTINGENT BENEFICIARY
Not applicable in Quebec, the provisions of the Civil Code shall apply.
For other provinces: Complete this section **ONLY** if you have designated a minor beneficiary.

FULL NAME OF THE TRUSTEE		RELATIONSHIP TO THE BENEFICIARY	
ADDRESS: Number, street, apt.	CITY	PROVINCE	POSTAL CODE

6 - AUTHORIZATION

I authorize my employer, the policyholder, the insurers, and their respective representatives to give, receive and share any personal information regarding my eligibility and my insurability or those of my dependents, if any, under this Program, within the limits of the law regarding the protection of personal information.

I hereby accept the conditions of this policy and I authorize the necessary contributions to be made through salary deductions.
I agree to the use of a Participant's number under this plan and as my identifier for my Employer's Group Insurance Program.

In case of death, I expressly authorize the policyholder, the employer, the beneficiary, heir or liquidator of my estate to provide the insurers, when required, with all the information and authorizations pertaining to the adjudication of the claim and the obtaining of evidence.

This consent is valid for the purpose of this policy, or any modification, extension or reinstatement of thereof.
A photocopy of this consent is as valid as the original if it used for information sharing purposes.

EMPLOYEE SIGNATURE	DATE (MM/DD/YYYY)