

MEMBER APPLICATION – GROUP BENEFITS ENROLMENT

PLEASE PRINT LEGIBLY



MEMBER INFORMATION						
LAST NAME			FIRST NAME			
STREET ADDRESS			CITY	PROVINCE	POSTAL CODE	
DATE OF BIRTH yyyy/mm/dd			SEX	PROVINCIAL HEALTH CARE NO. (BC RESIDENTS ONLY)		
WORK EMAIL			PERSONAL EMAIL			
MARITAL STATUS? <input type="checkbox"/> MARRIED <input type="checkbox"/> COMMON LAW <input type="checkbox"/> SINGLE			IF COMMON LAW, PLEASE PROVIDE DATE OF COHABITATION (YYYY/MM/DD)			
LIST OF DEPENDENTS (Spouse, then dependents, oldest first)						
01	LAST NAME	FIRST NAME	SEX	DATE OF BIRTH yyyy/mm/dd	RELATIONSHIP	PROV HEALTHCARE # (BC RESIDENTS ONLY)
					Spouse	
02						
03						
04						
05						
Over-age dependent children may be eligible if they are in full-time attendance as a student at a recognized educational institute. Please complete an Application for Over-Age Dependent Child Benefits.						
BENEFICIARY DESIGNATION – Group Life, Basic AD&D/ASI and Long Term Disability Survivor Benefits (if applicable)						
If no beneficiary is designated by the employee, the benefit is payable to their estate. Percentages must total 100% to be valid.						
NAME OF BENEFICIARY			RELATIONSHIP TO MEMBER	% OF BENEFIT	DATE OF BIRTH yyyy/mm/dd	
For Quebec Residents Only:			In Quebec, the designation of your spouse as beneficiary is irrevocable unless otherwise specified. If beneficiary is shown as irrevocable, his/her consent is required to change it.		If the spouse is designated as beneficiary, this designation is: <input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable	
DECLARATION APPOINTING TRUSTEE (Complete if Beneficiary is under the age of majority) Not applicable in Quebec						
I hereby appoint _____ as Trustee to receive any amount due to any Beneficiary(ies) under the age of majority and declare the receipt of such Trustee shall be good discharge to The Group Insurer(s) for the amount so paid. And I do hereby authorize such Trustee, at his/her discretion, to expend all or any portion of such amount and/or the income there from for the maintenance or education of such beneficiary(ies).						
Address of Trustee: _____			Relationship: _____			
PLEASE INDICATE YOUR DESIRED COVERAGE LEVEL (All future changes should be reported to your plan administrator)						
EXTENDED HEALTH CARE		<input type="checkbox"/> S=Self Only (Single)	<input type="checkbox"/> C=Self and One Dependent (Couple)	<input type="checkbox"/> F=Self and Two or More Dependents (Family)	<input type="checkbox"/> O=No coverage for myself or my Dependents	
DENTAL CARE		<input type="checkbox"/> S=Self Only (Single)	<input type="checkbox"/> C=Self and One Dependent (Couple)	<input type="checkbox"/> F=Self and Two or More Dependents (Family)	<input type="checkbox"/> O=No coverage for myself or my Dependents	
CO-ORDINATION OF BENEFITS (What is your coverage level?)						
EXTENDED HEALTH CARE		<input type="checkbox"/> S=Self Only (Single)	<input type="checkbox"/> C=Self and One Dependent (Couple)	<input type="checkbox"/> F=Self and Two or More Dependents (Family)	<input type="checkbox"/> O=No coverage for myself or my Dependents	
DENTAL CARE		<input type="checkbox"/> S=Self Only (Single)	<input type="checkbox"/> C=Self and One Dependent (Couple)	<input type="checkbox"/> F=Self and Two or More Dependents (Family)	<input type="checkbox"/> O=No coverage for myself or my Dependents	
WAIVER OF EXTENDED HEALTH AND/OR DENTAL COVERAGE						
I understand the plan of Group Insurance offered to me. However, if permitted by the provisions of the plan, I wish to waive the following benefits. I recognize that if my alternate coverage terminates, I must apply for coverage under my employer's Group Plan within 31 days of the termination date. Should I fail to do so, I may be required to submit, at my own expense, satisfactory evidence of insurability for myself and my dependents, or I may be required to pay premiums retroactive to the date of eligibility or benefits may be restricted or denied.						
EXTENDED HEALTH CARE:		<input type="checkbox"/> Myself	<input type="checkbox"/> My Dependents	DENTAL CARE:		<input type="checkbox"/> Myself <input type="checkbox"/> My Dependents
<input type="checkbox"/> I confirm that I have comparable coverage provided for me and/or my dependents under the following benefits plan:						
Name of Employer: _____		Name of Insurer: _____		Group Number: _____		
MEMBER AUTHORIZATION - PLEASE READ, SIGN AND DATE						
I hereby apply for group benefits coverage provided by my employer and authorize the regular deduction from my pay for any contributions to be made by me in relation to benefits. In regard to these and other benefits for which I am applying or will apply, I am providing certain personal information about myself and my family (if appropriate) and I hereby provide consent to my employer, GroupHEALTH Benefit Solutions (GroupHEALTH), the plan insurers or providers or their agents to collect, use, and disclose any and all information necessary to establish and maintain my benefits. I also understand that GroupHEALTH will acquire information about me and my family in the course of the provisions of benefits, satisfying any claims made, responding to insurer or provider requests and all other information for the purpose of determining eligibility, administration of benefits, satisfying any claims made, responding to insurer or provider requests and all other purposes reasonably necessary to maintain my benefits in good standing. I understand that no personal information will be disclosed for any other purpose without my consent. I confirm I am authorized to act on behalf of my spouse and/or dependents for such purposes. I declare this information is true, complete and accurate. Any copy of this authorization is as valid as the original. For further details regarding our personal information handling practices, please review our Privacy Policy located at https://www.grouphealth.ca/privacy-and-legal/ .						
MEMBER SIGNATURE				DATE		
EMPLOYER SECTION						
EMPLOYER NAME				PERSONAL IDENTIFICATION NUMBER (9 digits)		
EMPLOYEE NUMBER		OCCUPATION				
DATE OF PART-TIME EMPLOYMENT	DATE OF FULL-TIME EMPLOYMENT	DATE ELIGIBLE FOR COVERAGE	ANNUAL EARNINGS	# OF HOURS PER WEEK/F.T.E.	CLASS	DEPT/DIV/LOCATION
____/____/____ yyyy/mm/dd	____/____/____ yyyy/mm/dd	____/____/____ yyyy/mm/dd				