



195 King Street  
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## EMPLOYEE ENROLLMENT

### Employer / Plan Sponsor Section

Company Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
*If not yet assigned, leave blank*

Date of Hire / Re-hire: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Occupation: \_\_\_\_\_ Does the waiting period apply?  Yes  No

Class / Division: \_\_\_\_\_ Annual Earnings: \_\_\_\_\_

### Employee / Participant Details

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Sex:  M  F Date of Birth: (dd/mm/yyyy): \_\_\_\_\_

Marital Status: \_\_\_\_\_

### Applying for Coverage

Please check all that apply

Health	Dental	
<input type="checkbox"/>	<input type="checkbox"/>	Single (Myself ONLY)
<input type="checkbox"/>	<input type="checkbox"/>	Family (Myself and dependents as outlined in Dependent Details)
<input type="checkbox"/>	<input type="checkbox"/>	Waived (None. I have coverage through my spouse)

### Dependent Details

	Last Name	First Name	Sex	Date of Birth dd/mm/yyyy
Spouse			<input type="checkbox"/> M <input type="checkbox"/> F	
Child 1			<input type="checkbox"/> M <input type="checkbox"/> F	
Child 2			<input type="checkbox"/> M <input type="checkbox"/> F	
Child 3			<input type="checkbox"/> M <input type="checkbox"/> F	
Child 4			<input type="checkbox"/> M <input type="checkbox"/> F	

**Please indicate below if any of your dependents are full time students over age 21**

Name of Over Age Student	College/University Attended	Enrolled From	Enrolled To
_____	_____	_____	_____
_____	_____	_____	_____

Please indicate the name of any disabled dependents: \_\_\_\_\_

**Co-ordination of Benefits / Refusal of Coverage**

If you and/or your dependents are presently insured for Health Care and/or Dental benefits under your spouse's group policy you may co-ordinate benefits or refuse coverage under this contract by completing the appropriate areas.

**Health Coverage**

- I refuse insurance on myself and dependents
- I refuse insurance on my dependents
- I wish to coordinate with my spouse's plan

**Dental Coverage**

- I refuse insurance on myself and dependents
- I refuse insurance on my dependents
- I wish to coordinate with my spouse's plan

My spouse has coverage through \_\_\_\_\_(insurance company) under policy # \_\_\_\_\_

**Stop Loss Coverage (for Health Coverage Only)**

As part of the Health benefit provided through my employer (myself and my dependents) wish to be insured under the group insurance stop loss protection program.

Note: For consideration under this policy the following questions must be completed

1. Have you or any of your dependents, on an individual basis, incurred more than \$1,750.00 in health expenses in the last twelve (12) month period?

Yes       No      If yes, the approximate amount incurred: \$ \_\_\_\_\_

Name of applicable person (dependent): \_\_\_\_\_ DOB: \_\_\_\_\_

I hereby authorize the release of medical claims information solely for the purposes of determining eligibility and validating claims under this policy. I understand that this information can be forwarded to any other third party and will only be used for determining eligibility and validating the claim according to the terms of the Group Insurance Stop Loss Policy.

**Authorization**

By enrolling in this plan I am authorizing the applicable insurance carriers, agents and service providers to use and exchange information collected in this form to underwrite, administer and adjudicate claims. I also authorize my plan sponsor to use this same information for benefits administration and to make any necessary payroll deductions, which may be required.

Employee / Participant Signature: \_\_\_\_\_

Employee / Participant Name (Please Print): \_\_\_\_\_

Date: \_\_\_\_\_