SmartChoice BENEFITS

GROUP BENEFITS ENROLMENT APPLICATION

Please PRINT clearly. Complete the form in **INK**, sign and date the form and return to your plan administrator for handling.

1 Plan Sponsor Section

To be completed by plan administrator.

Please note the policy waiting period will be applied to the eligible date of employment.

Plan sponsor name

Company name

Division Name

◯ New plan member
◯ Re-hire

Full Time Hire Date (mm/dd/yyyy)

Re-hire Date (mm/dd/yyyy)

If re-hire when did previous employment end (mm/dd/yyyy)

Effective date of coverage (mm/dd/yyyy)

Employee number

Class

Occupation

Earnings: $ _____

◯ Annual ◯ Bi-weekly ◯ Weekly ◯ Other _____
◯ Monthly ◯ Semi-monthly ◯ Hourly (Hrs./Wk. _____)

Business address

Postal code

City

Province

Telephone number

Fax Number

2 Employee Information

To be completed by the employee

Please print clearly, in INK

We require this information to enrol you in the plan

Last name

Middle initial

First name

Gender ◯ Male ◯ Female

Date of Birth (mm/dd/yyyy)

Language of preference ◯ English ◯ French

Home or mailing address

City

Province

Postal code

Telephone number

Cell number

Email address

Marital status ◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Widowed ◯ Common law

If common law provide date started living together _____ (mm/dd/yyyy)

Coverage Applying for ◯ Single ◯ Couple ◯ Family

If you are refusing Health/ Dental benefits please complete section 3 and provide spouse and carrier details

If you or your dependents are currently covered for ***Health and/or Dental benefits*** under another plan, such as a spouse's plan, you may refuse to be covered for these benefits by selecting the applicable box below.

◯ I refuse coverage for myself and my dependents ◯ Extended Health Care ◯ Dental Care

◯ I refuse coverage for my dependents only ◯ Extended Health Care ◯ Dental Care

If your spouse's coverage terminates, you must apply for health and dental benefits within 31 days from the date your spouse's coverage ends. If you do not apply within 31 days, you and/or your dependents may be required to provide satisfactory medical evidence for the insurance carrier's review. If you are approved, coverage for the dental benefits may be limited for the first year.

3 Dependent Information

Spouse details

Complete this section if you are enrolling your spouse **and/or** if you are refusing health/dental coverage for your spouse

Claims for a spouse must **first** be sent to his/her own employer's plan

Spouse's last name | Middle initial | Spouse's first name

Date of birth (mm/dd/yyyy)

Gender ◯ Male ◯ Female

Is your spouse covered through his/her employer for Extended Health Care and/or Dental Care benefits?

◯ Yes ◯ No

Extended Health Care ◯ Single ◯ Family

Dental Care ◯ Single ◯ Family

Effective date (mm/dd/yyyy)

Name of spouse's employer _____ Policy No. _____

Name of insurance Carrier _____ Certificate No. _____

Where applicable, benefit payments will be coordinated between this plan and your spouse's plan.

Children details

Claims for covered children must be sent to the plan of the parent whose birthday falls first in the calendar year

If there are more than 6 children please complete the attached page.

Child's last name	Child's first name	Date of birth (mm/dd/yyyy)	Gender	Full- time student* (Over 21)	Over-age Disabled Child**
			◯ M ◯ F	◯ Yes	◯ Yes
			◯ M ◯ F	◯ Yes	◯ Yes
			◯ M ◯ F	◯ Yes	◯ Yes
			◯ M ◯ F	◯ Yes	◯ Yes
			◯ M ◯ F	◯ Yes	◯ Yes
			◯ M ◯ F	◯ Yes	◯ Yes

* **Full-time student: Proof of registration is required** for a dependent child age 21 or over, but under age 26, who is a full-time student attending an accredited educational institution, college or university, as long as the dependent child is not married or in any other formal union and is entirely dependent on you for financial support. ***Proof of registration is required prior to the beginning of each school year***.

For Quebec plan members, please check with your plan administrator for dependent student age limit.

** To enrol an over-age disabled child, you will need to complete a Disabled Child Coverage form, and send it to us within 31 days of the date the dependent reaches the age limit. Please see your plan administrator.

The information being collected will be used to provide benefit coverage for an employee's eligible spouse or benefit partner and children. It is protected by the privacy provisions of the Personal Information Protection and Electronic Documents Act. If you have any questions about the collection and use of this information, contact your Plan Administrator. You are responsible for advising your Plan Administrator of any changes to your dependent information.

4 Beneficiary Designation

To be completed by the employee.

The original of this form will be required for Life and/or Accidental Death claim

You must initial any changes or deletions. Correction fluid cannot be used.

Percentage must total 100% to be valid

Note: If a beneficiary is not assigned, "Estate" will be assumed and any proceeds will be paid to your estate.

Name of Beneficiary (first and Last name)	Relationship to employee	Date of birth (mm/dd/yyyy)	Percentage

For Quebec residents only. In Quebec the designation of your spouse as beneficiary is irrevocable unless otherwise specified.

◯ Revocable ◯ Irrevocable

If the beneficiary is shown as irrevocable, his/her consent is required to change it.

5 Contingent Beneficiary

To be completed by the employee.

If there is no surviving primary beneficiary(ies) at the time of your death, the contingent beneficiary(ies) will be entitled to receive the proceeds. If there is no surviving contingent beneficiary(ies) at the time of your death, the proceeds shall be paid to your estate.

Name of Contingent Beneficiary (first and Last name)	Relationship to employee	Date of birth (mm/dd/yyyy)	Percentage

6 Trustee Appointment

To be completed by the employee.

Complete this section if any beneficiary or contingent named is under the age of majority..

Name of Trustee (first and Last name)

Note: In Quebec any amount payable to a beneficiary under the age of majority will be paid to the parent(s) or legal guardian on his/her behalf.

7 Authorization and Signature

This designation must be ***signed and dated*** to be valid

Reset Form

Print Form

I certify that the information given on this form is true, correct and complete to the best of my knowledge. I understand that I may be required to provide proof of evidence of this information. I hereby accept the conditions of this policy and I authorize the necessary contributions to be made through salary deductions, if applicable. I authorize my Employer, the Policyholder, the Plan Administrator and the Insurance Company (ies) or their re-insurers, or their respective agents to give, receive and share any personal information regarding my eligibility and my insurability or those of my dependents, if any under this plan.
In the case of death, I expressly authorize my Employer, the Policyholder, the Plan Administrator, the Beneficiary, heir or liquidator of my estate to provide the Life Insurance Company, when required by the latter, with all the information and authorizations permitting the assessment of the claim and the collection of evidence.
This consent is valid for the purpose of this contract, or any modification, extension or reinstatement thereof.
A photocopy of this consent is valid as the original if it is used for information-sharing purposes.

Plan member signature

Date signed (mm/dd/yyyy)

25 North Rivermede Road, Unit 19, Concord Ontario L4K 5V4
Tel: 905.660.0572 Fax : 905.660.4199 Toll free : 1.800.567.0156