GroupBenefitz™
Record of Enrollment

MEMBER INFORMATION

Full Name

Email

Phone Number

Date of Birth

Gender

ELIGIBILITY

Company Name

Date of Hire

Job Title

Hours per week worked

☐ I confirm that I am actively working 20+ hours to meet eligibility.

☐ I confirm that I have provincial health coverage in my province of residence.

MAILING ADDRESS

Street Address

Street Address Line 2

Apt./Suite Number

City

Province

Postal Code

DEPENDENTS

Type	First Name	Last Name	Gender	Date of Birth	Coverage with another plan	Carrier	Post Secondary Student	Graduation Day	Special Needs

SELECTED PLANS

Name	Details	Amount	Tax	Total

☐ I have read and agreed to the **terms & conditions.**

☐ I have read and agreed to the **advisor disclosure.**

Payment Method

Date of Enrollment

Your Advisor's Name

Member Signature

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ADDENDUM

SELECTED PLANS

Name	Details	Amount	Tax	Total

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