HealthSource Plus

HealthSource Plus is a People Corporation company

GROUP ENROLMENT FORM

Please print clearly, use INK, sign and date the form.

1 EMPLOYER INFORMATION. To be completed by Plan Administrator.

Company Name	Employee Number	Division	Class	Certificate Number

Employee Hire/Reinstatement Date (dd/mm/yy)	Effective Date of Coverage (dd/mm/yy)	Is the waiting period being waived? ☐ Yes ☐ No If **yes**, please attach letter of explanation

Salary $	Number of regular hours worked per week?

Salary Basis (check one): ☐ Hourly ☐ Monthly ☐ Bi-weekly ☐ Weekly ☐ Annual	Employee Occupation

INSTRUCTIONS GUIDE

Completed original forms should be saved in employee files.

HSP will assume employee works 52 weeks per year – if this varies, please contact your Client Service Specialist

2 EMPLOYEE INFORMATION. To be completed by Employee.

Employee Last Name	Employee First Name	☐ Male ☐ Female

Date of Birth (DD/MM/YYYY)	Language Preference ☐ English ☐ French	Home Phone, including area code

Street Address	Suite Number

City	Province	Postal Code	Employee Email Address

What type of coverage are you applying for? (check one) ☐ None (please complete Refusal of Coverage section) ☐ Single ☐ Family

Please ensure to print clearly, to ensure accurate entry of your information.

Please ensure your full and complete address is provided including the postal code.

If you have questions on the type of coverage to select, please speak to your plan administrator

3 FAMILY DETAILS

Do you have a spouse? ☐ Yes ☐ No **If common-law**, when did you start living together? (dd/mm/yy)

Last Name		Gender	Date of Birth (dd/mm/yy)
First Name		☐Male ☐Female	

Are any of your dependents OVER AGE DEPENDENTS? (over the maximum age for a child, as noted in your contract, and either disabled or enrolled in a full-time post secondary institute)

If they are a student, please include current proof of full-time enrolment

If they are disabled, please contact your plan administrator for the required forms for completion

Child Last Name	Child First Name	Gender	Date of birth (dd/mm/yy)	Overage Student	Disabled
		☐Male ☐Female		☐Yes ☐No	☐ Yes ☐ No
		☐Male ☐Female		☐Yes ☐No	☐ Yes ☐ No
		☐Male ☐Female		☐Yes ☐No	☐ Yes ☐ No

Please print clearly, to ensure accurate entry of your information.

Please ensure all eligible dependent information is included at time of enrolment, to avoid delays in entry, or late applicant restrictions later.

When providing school information for Over Age Dependents, please ensure it clearly indicates dependent name, enrolment period, and confirmation of full-time enrolment status.

4 COORDINATION OF BENEFITS. To be completed by Employee, if applicable.

If you, your spouse or your dependents are covered for Extended Health Care and/or Dental Care benefits under another group insurance plan please complete this section.

Extended Health Care	☐ None	☐ Single	☐ Family	☐ Couple	☐ Single Parent
Dental	☐ None	☐ Single	☐ Family	☐ Couple	☐ Single Parent

Coordination coverage may include spousal plan, alternate employer, etc.

If an employee has coverage under two group plans, as the primary plan member, the plan with the earlier effective date will be first payer

5 REFUSAL OF COVERAGE. To be completed by Employee, if applicable.

If you or your dependents are presently covered for Extended Health Care and/or Dental Care benefits under another group insurance program you may refuse Extended Health or Dental Care coverage by selecting the applicable box for each benefit:

I am refusing coverage for:	DENTAL ☐ Myself & My Dependents ☐ My Dependents only	**Health** ☐ Myself & My Dependents ☐ My Dependents only

Only health and dental coverage may be refused, if the employee and/or dependents have coverage elsewhere.

All other benefits are mandatory.

For any questions, please contact your Plan Administrator.

MUST ANSWER IF YOU ARE REFUSING HEALTH AND DENTAL COVERAGE:

Are you or your dependents now covered by any other group plan? Yes No

If yes: Policy holder's name: _____ Carrier_____

I understand that I am refusing insurance because myself and/or my dependents are insured under another applicable insurance plan.

Should I wish to join this plan at a later date, I understand that I must request enrollment within 31 days following the termination of other applicable insurance plan or approved life event.

If Dental coverage is refused, I understand that my benefits may be reduced if I later wish to enroll for this coverage.

I understand that I may be required to provide, at my expense, evidence of insurability satisfactory to the insurer, if later wish to enroll in any other coverage that is now being refused.

_____ DATE OF REFUSAL

_____ SIGNATURE IF REFUSING ANY COVERAGE

6 PRIMARY BENEFICIARY DESIGNATION. To be completed by Employee.

The plan member is the beneficiary of insurance on the lives of his or her dependents. Unless otherwise stipulated or prohibited by law, the designation is Revocable. If the beneficiary is shown as Irrevocable, his/her consent is required to change it. In Quebec the designation of your spouse (marriage or civil union) as beneficiary is Irrevocable unless otherwise specified.

Last Name	**First Name**	**Date of Birth (dd/mm/yy)**	**Relationship to Employee**	**Percentage (must total**
				%
				%
				%

If you are a resident of the province of Quebec and you name your legal spouse (married or civil union) as the beneficiary, this beneficiary will be irrevocable unless you check the revocable box ☐ Revocable Beneficiary

Minor Clause, (Trustee for children under the Age of Majority – Excluding Quebec residents)

Trustee Name	Relationship to Life Insured

As indicated above the trustee is hereby appointed to receive any payment due on or after the life insured's death to any **BENEFICIARY DESIGNATED** on this form who is a minor on the date such payment(s) fall due.

Revocable – can be changed without the consent of the beneficiary

Irrevocable – Named beneficiary must sign off on any changes

7 CONTINGENT BENEFICIARY To be completed by Employee, if applicable.

If there are no surviving beneficiaries at the time of my death, I declare that the following contingent beneficiaries shall receive the proceeds. If there are no surviving contingent beneficiaries at the time of my death, the proceeds shall be paid to my estate. Unless specified otherwise, my contingent beneficiaries will apply to all my benefits. The designations you make on this form replace any prior beneficiary designations.

Last Name	**First Name**	**Date of Birth**	**Relationship to Employee**	**Percentage of Benefit**
				%
				%

If you are a resident of the province of Quebec and you name your legal spouse (married or civil union) as the beneficiary, this beneficiary will be irrevocable unless you check the revocable box ☐ Revocable Beneficiary

Can be used as a secondary beneficiary designation in the event the original designated beneficiary predeceases the insured.

8 Authorizations & Declarations. To be completed by Employee (sign and date in ink).

1. I designate the person(s) named above under Beneficiary Designation as beneficiary(s).
2. I declare that the information I have provided on this form is true and complete, and understand that if any of the information provided is incomplete or false my benefits may be terminated.
3. A photocopy or electronic version of this authorization is as valid as the original.
4. I certify that I am authorized to disclose and receive information about my Spouse and/or Dependents.
5. I authorize my Plan Administrator (HealthSource Plus) to use my social insurance number for tax reporting purposes and as an identification number where required for the administration of the plan.
6. I authorize my Plan Administrator (HealthSource Plus), its agents, insurers and service providers to use and exchange information collected in this form to underwrite, administer, determine eligibility and adjudicate claims.
7. I authorize my Plan Administrator (HealthSource Plus), Plan Sponsor as required, to use the information collected in this form to make any necessary payroll deductions which may be required.
8. I understand that the Plan Administrator shall have the right to recover from me any payments made in error.

Plan Member Signature	**Date** DD/MM/YYYY

Employer Authorization. To be completed by Plan Administrator.

I declare that the information provided on this form is complete and accurate to the best of my knowledge, and **I authorize** HealthSource Plus to use this information to administer the group benefits plan; obtain quotes for underwritten/insured products within the plan; verify the identity and eligibility of the plan member, spouse or eligible dependents; adjudicate and pay eligible claims; audit plan expenditures; and, prepare reports. **I understand** this information will only be provided to those insurers/adjudicators contracted by HealthSource Plus to provide services within the plan. **I declare** I have obtained the Consent of this Employee (and the consent of the spouse or partner where applicable) to provide this information to HealthSource Plus.

Name	**Signature**	**Date** DD/MM/YYYY

ABOUT YOUR PRIVACY: At HealthSource Plus, we recognize and respect the importance of privacy. Any information you provide us will be kept in a group life and health benefits file. We limit access to personal information to authorized staff or persons authorized by HealthSource Plus who require it to perform their duties, to persons you have granted access, and to persons authorized by law. We use the information you provide us for the administration, eligibility and adjudication of your benefits under your plan.