studentVIP

GROUP BENEFITS ENROLLMENT APPLICATION

1 Plan Sponsor Section

Plan sponsor name

Smartchoice Benefits

Association name

2 Member Information

To be completed by the member

We require this information to enrol you in the plan

Last name | Middle initial | First name

Gender ◯ Male ◯ Female ◯ Undisclosed ◯ Non-Binary

Date of Birth (mm/dd/yyyy)

Language of preference ◯ English ◯ French

Student ID

Plan Enrollment Date

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)

Are you covered by a Parental Health Insurance Plan? ◯ Yes ◯ No

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

Are you a Foreign Student? ◯ Yes ◯ No

◯ Yes ◯ No

Coverage Applying for ◯ Single ◯ Couple ◯ Family

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 my dependents only

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 ◯ Undisclosed ◯ Non-Binary

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

◯ Yes ◯ No

Name of insurance Carrier _____

Extended Health Care ◯ Single ◯ Family

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**
				◯ Yes	◯ Yes
				◯ Yes	◯ Yes
				◯ Yes	◯ Yes
				◯ Yes	◯ Yes
				◯ Yes	◯ Yes
				◯ 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*:**

** 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 a member'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 Selected Plans

Plan	Type	Monthly Premium	Tax	Total

5 Authorization and Signature

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

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 bank account deductions. I authorize 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 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)