MEMBER APPLICATION
GROUP BENEFITS ENROLMENT

SOURCE SELECT MARKETING

MEMBER INFORMATION

LAST NAME	FIRST NAME	INITIAL	DATE OF BIRTH	GENDER
Israel	Jan Francis	P	1988-12-27	Male

ADDRESS	CITY	PROVINCE	POSTAL CODE
192 Somerside Way SE	Medicine Hat	AB	T1B 0M3

PERSONAL PHONE #	PRIMARY EMAIL	PERSONAL EMAIL
403-307-4402	janis@sourceselect.ca	janfrancisisrael@gmail.com

EXTENDED HEALTH CARE COVERAGE

NAME	RELATIONSHIP TO MEMBER	COVERAGE (YES/NO)
Jan Francis P Israel	Member	Yes

DENTAL CARE COVERAGE

NAME	RELATIONSHIP TO MEMBER	COVERAGE (YES/NO)
Jan Francis P Israel	Member	Yes

MEMBER ADVANTAGE INSURANCE POLICY

NAME	RELATIONSHIP TO MEMBER	COVERAGE (YES/NO)
Jan Francis P Israel	Member	No

BENEFICIARY DESIGNATION

BENEFICIARY FOR YOUR GROUP BENEFITS POLICY			
NAME OF BENEFICIARY	RELATIONSHIP TO MEMBER	% OF BENEFIT	AGE
Estate		100	

I hereby appoint the beneficiaries listed above to receive the Insurance benefits which are payable in the event of my death. I reserve the right, without the consent of the beneficiaries, to further change the beneficiary subject to any statutory restrictions. I also hereby revoke any previously designated beneficiaries, subject to any statutory restrictions. If no designated beneficiary survives me, settlement will be made to my Estate.

MEMBER AUTHORIZATION

I hereby apply for group benefits coverage provided by my employer and authorize the regular deduction from my pay for any contributions to be made by me in relation to benefits.

I am, on behalf of myself, my spouse and/or dependents:

- providing, and I confirm that I have the right to provide, personal and health information about myself and my family. In addition, I also understand that GroupHEALTH Global Benefit Systems Inc. ("GroupHEALTH") will acquire information about me and my family in the course of, but not limited to, the provision of benefits and satisfying any claims made and responding to insurer or provider requests.
- consenting, and confirming that I have the right to consent, to my employer, and to GroupHEALTH to collect and disclose any and all such information to the plan insurers and re-insurers, providers and anyone necessary for the provision of benefits, and to disclose my and my family's personal and health information to our physician(s), the Public Health Authorities, as necessary, and for additional purposes listed specifically in the privacy policy located at https://www.grouphealth.ca/privacy-and-legal/. No personal health information about myself or my family will be disclosed to my employer.
- consenting, and confirming that I have the right to consent, to GroupHEALTH, the plan insurers, reinsurers, providers and anyone necessary for the provision of benefits to use all such information to underwrite my application for group benefits and optional insurance (if applicable), evaluate my, my spouse's and/or my dependents' eligibility, administer my benefits, to satisfy any claims made, all other purposes reasonably necessary to maintain my benefits in good standing and for additional purposes listed specifically in the privacy policy located at https://www.grouphealth.ca/privacy-and-legal/.

By completing this form, I, and my spouse and/or dependents, consent to the use of an electronic acceptance.

Any copy of this authorization is as valid as the original.

Signature: Jan Francis Israel **Date:** 2024 / 11 / 20

Dropbox Sign

Audit trail

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