

# Employee Benefits Enrollment Form



## Part A: Employee to complete in ink

### Personal Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  Mr.  Mrs.  Ms.  Miss

Address: \_\_\_\_\_ Apt. # \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Date of Birth: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_ S.I.N. : \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Sex:  M  F

Marital Status:  Single  Married  Separated  Divorced  Common Law Length of C/L Relationship: \_\_\_\_\_

### Dependant Information

Please list all dependants including your spouse, common-law spouse (relationship of at least one year), and/or children. Refer to your benefits booklet or ask your employer to confirm who is considered an eligible dependant. Complete an "Overage Dependant" form if applicable.

| Spouse's Last Name |       | First Name |   | Date of Birth   |                       |        |
|--------------------|-------|------------|---|---|-----------------------|--------|
|                    |       | (Month)    | (Day)   | (Year)  |                       |        |
| _____              |       | _____      |   | <input type="checkbox"/> M <input type="checkbox"/> F | _____ / _____ / _____ |        |
| Child's Last Name  |       | First Name |   | (Month)   | (Day)                 | (Year) |
| 1. _____           | _____ |            | <input type="checkbox"/> M <input type="checkbox"/> F | _____ / _____ / _____                                 |                       |        |
| 2. _____           | _____ |            | <input type="checkbox"/> M <input type="checkbox"/> F | _____ / _____ / _____                                 |                       |        |
| 3. _____           | _____ |            | <input type="checkbox"/> M <input type="checkbox"/> F | _____ / _____ / _____                                 |                       |        |
| 4. _____           | _____ |            | <input type="checkbox"/> M <input type="checkbox"/> F | _____ / _____ / _____                                 |                       |        |

Does your **spouse** have benefits coverage through his/her employer's plan?  No  Yes. If Yes:  Single  Family

### Selection of Coverage

Please indicate Single coverage (for yourself only), Family coverage (for yourself and your dependants), or Waived (no coverage for yourself and no coverage for your dependants).

Health and Dental Benefits:  Single  Family  Waived

You may only Waive coverage for yourself and your dependants if you are covered for similar benefits under your spouse's plan.

Provide the name of your Spouse's Employer and Insurance Company below:

Spouse's Employer: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

### Revocable Beneficiary Designation

If your beneficiary is a child under age 18, you must also complete a "Declaration Appointing Trustee" form. If you make any changes or corrections in this section, you must initial the change or correction.

| Beneficiary's Last Name | First Name | Relationship (e.g. spouse, child) | Age<br>(If a child) |
|-------------------------|------------|-----------------------------------|---------------------|
| _____                   | _____      | _____                             | _____               |

For Quebec residents: the appointment of a spouse as Beneficiary is considered "IRREVOCABLE" unless the word "REVOCABLE" is written after the spouse's name.

### Employee Authorization

I hereby apply for the benefits for which I am or may become eligible, subject to any waiver indicated, under the Benefit Services Contract issued by The Benefits Trust and authorize that any required contributions be deducted from my earnings. In addition, I authorize The Benefits Trust and its administrators to use my social insurance number, if applicable, for identification purposes in the administration of the Benefit Services Contract. On behalf of myself and my dependants, I also authorize The Benefits Trust (including its affiliates and/or insurance partners) to exchange the information detailed in this Enrollment and any other benefit related information contained in files regarding me or my dependants, now or in the future, for the purposes of administration and/or management of the Benefit Services Contract issued by The Benefits Trust.

Employee Signature: \_\_\_\_\_ Date: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

**Part B: Employer to complete in ink**

**Instructions to Employer:**

1. This application **must** be completed in **INK**.
2. Before submitting this application to The Benefits Trust please ensure that it has been completed fully. An incomplete form will delay the employee's enrollment in the benefits plan.
3. This application **must be** received by The Benefits Trust **within 31 days** of the employee becoming eligible to join the benefits plan. If the application is received after such time, the applicant will be treated as a **LATE ENTRANT** and may be required to submit evidence of insurability to be eligible for benefits coverage.

**Contractholder Information**

Name of Employer \_\_\_\_\_ Group / Policy Number \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

**Employee Coverage and Eligibility Information**

|                       |               |          |            |          |                                   |
|-----------------------|---------------|----------|------------|----------|-----------------------------------|
| Employee's Occupation | Benefit Class | Division | Department | Earnings | <input type="checkbox"/> Annually |
| _____                 | _____         | _____    | _____      | _____    | <input type="checkbox"/> Monthly  |
|                       |               |          |            |          | <input type="checkbox"/> Weekly   |
|                       |               |          |            |          | <input type="checkbox"/> Hourly   |

Date Employed on a Full-time Basis: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_ Date Coverage To Begin: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

**Employer Comments** Please note any exceptions or other comments (e.g. waive normal waiting period requirement; employee is on disability or leave of absence; special terms of employment contract which could affect benefits coverage)

**Employer Authorization**

Authorized Signature: \_\_\_\_\_ Date: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

**FOR INTERNAL USE ONLY**

**THE BENEFITS TRUST is administered by:**

The Benefits Trust Inc.  
 3800 Steeles Avenue West, Suite 102W, Vaughan, Ontario L4L 4G9  
 Phone: 416-498-7723 or 905-264-8990 Fax: 905-264-1123  
 Toll Free: 1-800-487-2993