Employee Benefits Enrollment Form

the benefits trust

Part A: Employee to complete in ink

Personal Information

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

Last Name: _____ First Name: _____

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.

			Date of Birth (Month)	(Day)	(Year)
Spouse's Last Name	First Name				
_____	_____	☐ M ☐ F	_____ /	_____ /	_____
Child's Last Name	**First Name**		**(Month)**	**(Day)**	**(Year)**
1. _____	_____	☐ M ☐ F	_____ /	_____ /	_____
2. _____	_____	☐ M ☐ F	_____ /	_____ /	_____
3. _____	_____	☐ M ☐ F	_____ /	_____ /	_____
4. _____	_____	☐ M ☐ 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 (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 dependents, 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 dependents, 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) _____

REVERSE SIDE - TO BE COMPLETED BY EMPLOYER

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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

_____ _____ _____ _____ _____

- ☐ Annually
- ☐ Monthly
- ☐ Weekly
- ☐ 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.
1453 Pelham St, Fonthill, Ontario, L0S 1E0

Phone: 416-498-7723 or 905-264-8990 Fax: 905-264-1123
Toll Free: 1-800-487-2993