



500-2755 Lougheed Highway
Port Coquitlam, BC, V3B 5Y9

Group Insurance Enrolment

- New Employee
 Reinstatement

Name of Employer

► This application is to be completed in BLUE INK. PLEASE PRINT. Please submit original application only — fax copies or photocopies cannot be accepted ◀

Employee – Complete this section ◀

| Employee Last Name | | First Name | | Initial | Are you covered under your Provincial Health Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
|---|-----------------|-------------------|---------|-----------------------|--|-------------------|---------------------|--|
| Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | Month | Birth Date Day | Year | Province of Residence | Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Common Law <input type="checkbox"/> Married <input type="checkbox"/> Divorced Date of Cohabitation _____ | | | |
| Dep. No. | List Dependents | | | Sex | Birth Date | | Relationship to You | If child is over plan's age limit (e.g. 19 or 21), and attending school full-time, provide name of school. If child is handicapped, state nature of disability to apply for coverage beyond plan's age limits. |
| | Last Name | First Name | Initial | M/F | Month | Day | Year | |
| 01 | Spouse | | | | | | | |
| 02 | 1st Child | | | | | | | |
| 03 | 2nd Child | | | | | | | |
| 04 | 3rd Child | | | | | | | |
| 05 | 4th Child | | | | | | | |
| Do you have duplicate coverage under another Extended Health or Dental plan (e.g. your spouse's group plan)? If yes, provide: | | | | | | | | <input type="checkbox"/> EHC <input type="checkbox"/> Dental |
| Name of Insurance Company | | | | Group Number | | ID Number | | |
| Beneficiary Designation (use full legal name – e.g. Mary Jane Doe, not Mrs. John Doe) I designate as revocable beneficiary in the event of my death: | | | | | | | | |
| _____ % _____ % | | | | | | | | |
| Full Legal Name | | | | Relationship | | Share of Proceeds | | |
| Trustee Designation (complete only if beneficiary is under age 18) I appoint as revocable Trustee to receive any amount which may be due my beneficiary, while such beneficiary is a minor: | | | | | | | | |
| _____ | | | | | | | | |
| Full Legal Name | | | | Signature of Employee | | Date | | |

Partial Waiver

Employee – Complete this section if applicable ◀

I elect to waive the benefits checked below because comparable coverage is provided to me and/or my dependents under another group plan: (specify plan details below)

- For myself and my dependents Extended Health Care Dental Care
► For my dependents only Extended Health Care Dental Care

| | | |
|--|---|--|
| Name of Other Plan's Employer/Policyholder | Is this your spouse's group plan? <input type="checkbox"/> Yes <input type="checkbox"/> No (if no, provide details) | I certify that I have been given an opportunity to participate in my employer's plan. Comparable coverage is currently provided to me and/or my dependents under another group plan. I understand that if I cease to be covered under this other plan, and I then wish to participate in my employer's plan, I will have to complete an application within 31 days of loss of coverage. If application for coverage is not made within 31 days I will be required to furnish, at my own expense, evidence of insurability satisfactory to the insurers, and all coverage is subject to their approval. X _____ Signature of Employee Date |
| Name of Insurance Company | | |
| Group Number | | |

Employer – Complete this section ◀

| | | |
|--|---|--|
| Employee's Earnings \$ _____ <input type="checkbox"/> Annually <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Hourly | Hours Per Week | Payroll Number (optional) Department Number _____ Employee Number _____ |
| Employee's Occupation | Class Code | I confirm that this employee is eligible to apply for coverage and that the information I have provided is true and complete. X _____ Authorized Signature of Employer Date |
| Date of Employment (New Employee) Month _____ Day _____ Year _____ | Date of Rehire (Reinstatement) Month _____ Day _____ Year _____ | |
| Effective Date (for administrator use only) Month _____ Day _____ Year _____ | | |