



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 Last Name			Sex M/F	Birth Date Month Day Year	Relationship to You
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:						
Name of Insurance Company				Group Number	ID Number	<input type="checkbox"/> EHC <input type="checkbox"/> Dental
<b>Beneficiary Designation</b> (use full legal name – e.g. Mary Jane Doe, not Mrs. John Doe) I designate as revocable beneficiary in the event of my death:				I agree to the conditions of the contract(s) between my employer and the insurer(s) and authorize my employer to deduct required contributions from my earnings. On behalf of myself and my dependents I authorize Benefits by Design Inc. and all insurers to exchange the information detailed in this application, and any other benefit related information contained in files regarding me or my dependents, either now or in the future, for the purposes of administration and/or management of the group insurance policies issued by the insurers. I understand that this original document and all other original documents pertaining to me and my dependents are the property of Benefits by Design Inc. and will be permanently retained by Benefits by Design Inc. as required by the insurers. I confirm that the information I have provided is true and complete.		
Full Legal Name				Relationship	Share of Proceeds	
<b>Trustee Designation</b> (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:				<input checked="" type="checkbox"/> Signature of Employee _____ Date _____		
Full Legal Name						

## 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.
Name of Insurance Company		
Group Number		
		<input checked="" type="checkbox"/> Signature of Employee _____ Date _____

## ▶ 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.
Date of Employment (New Employee) Month Day Year	Date of Rehire (Reinstatement) Month Day Year	
Effective Date (for administrator use only) Month Day Year		<input checked="" type="checkbox"/> Authorized Signature of Employer _____ Date _____