



**MCCA ENROLLMENT FORM/REFUSAL OF BENEFIT  
GROUP BENEFIT PLAN FOR FAMILY CHILD CARE PROVIDERS**

<b>MCCA GROUP BENEFIT PLAN</b>	<input type="radio"/> <b>I will enroll</b>	<input type="radio"/> <b>DECLINE</b>	<i>If declined, please complete declaration of refusal on the bottom of this form</i>
<b>COVERAGE:</b> <i>Please check one, unless declined</i>	<input type="radio"/> <b>BASIC</b>	<input type="radio"/> <b>SINGLE</b>	<input type="radio"/> <b>FAMILY</b>
<b>APPLICANT INFORMATION:</b>  <i>Note: All information is kept in strict confidence.</i>  <b>Please print.</b>	Name: _____		
	Address: _____		
	City/Town: _____		Prov: _____
	Postal Code: _____	Phone: _____	
	Fax: _____	Email: _____	
<b>DECLARATION OF INSURABLE EARNINGS:</b>	Gross Child Care Income:		\$ _____
	Less 15% for Child Care Business Expenses:		- \$ _____
	Insurable Earnings:		= \$ _____

**MCCA GROUP BENEFIT PLAN**

**I understand and meet the following criteria:**

- Licensed family child care provider that is current member of the Manitoba Child Care Association.
- Licensed family child care provider that provides care for at least 20 hours per week.
- Premiums are due and payable to MCCA on the first day of each month according to the pre-authorized payment agreement.
- Changes made to the group insurance plan must be submitted in writing to MCCA prior to the 10th day of the month in order to become effective the first day of the following month.
- Cancellation of MCCA membership or Manitoba Child Care Program license will result in immediate termination of insurance coverage.
- NSF payments will result in an administration fee charged and the immediate suspension of all insurance coverage.



**Yes, I want to enroll in the MCCA Group Benefits plan, and I understand and meet the above criteria**

Please print name: \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_



**DECLARATION OF REFUSAL - No, I do not want to enroll in the MCCA Group Benefits plan.**

*Please read and sign at the bottom of the page, stated your decision to waive the group benefits plan.*

- I understand and have read the information pamphlet provided by MCCA in regards to group benefits. At this point in time, I decline all coverage.
- I understand that if I choose to join the benefit plan at a later date that I will be classified as a "late applicant" and will be restricted to benefits imposed from the insurance company. (ie: restrictions to dental, health, STD/LTD benefits etc.)

Please print name: \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE RETURN THIS FORM WITH YOUR MEMBERSHIP APPLICATION**