HealthSource Plus®
Group Benefits • Administration • Wellness • Retirement

Group Enrolment and Change Form

Please print clearly, use INK, sign and date the form.

1 Plan Sponsor Information. To be completed by Plan Administrator.

Plan Sponsor Name	Policy No.	Division	Certificate Number	Class Code

Member Hire/Reinstatement Date (DD/MM/YYYY)	**Is the waiting period being waived?** ☐ Yes ☐ No *If yes, please attach letter of explanation*	Effective Date of Coverage (DD/MM/YYYY)
Salary $	Number of regular hours worked per week?	Does the employee work less than 52 weeks per year? ☐ Yes ☐ No If yes, provide annual salary:
Salary Basis (check one): ☐Hourly ☐Monthly ☐Bi-weekly ☐Annual ☐Semi-Monthly		Employee Occupation

2 Plan Member Information. To be completed by Plan Member.

Plan Member Last Name		Plan Member First Name	
Date of Birth (DD/MM/YYYY)	Gender ☐ Male ☐ Female	Street Address	Suite Number
City		Province	Postal Code
Home Phone, including area code:		Do you have a spouse? ☐ Yes ☐ No	If common-law, indicate date of cohabitation. **(DD/MM/YYYY)**
Email:		Do you have eligible dependent children? ☐ Yes ☐ No If yes, how many?	
Language Preference ☐ English ☐ French		What type of coverage are you applying for? (check one) ☐ None ☐ Single ☐ Family ☐ Couple ☐ Single Parent	

3 Change Information. To be completed by Plan Administrator.

What is the effective date of the change? (DD/MM/YYYY)

☐ Member Termination (Indicate last day worked)	☐ Coverage Change (*Ensure plan member has completed the appropriate sections)*
☐ Member Class/Division Transfer (Indicate new class/division)	☐ Date of Birth (Indicate correct date of birth)
☐ Member Salary Change (Indicate old and new salary)	☐ Beneficiary Change (*Ensure plan member has completed section 7*)
☐ Add/Remove Spouse or Dependent (*Ensure plan member has completed all appropriate sections)*	☐ Address Change (*Ensure plan member has completed section 2*)
☐ Name Change	☐ Other

Provide change details:

4 Refusal of Benefits. To be completed by Plan Member.

If you or your dependents are presently covered for Extended Health Care and/or Dental Care benefits under another group insurance program you may refuse Extended Health or Dental Care coverage by selecting the applicable box for each benefit:

I refuse coverage for myself, my spouse and my dependents	☐ Extended Health Care	☐ Dental Care
I refuse coverage for my spouse and dependents	☐ Extended Health Care	☐ Dental Care
Spouse's Insurance Company:	Spouse's Employer:	

5 Coordination of Benefits. To be completed by Plan Member, if applicable.

If you, your spouse or your dependents are covered for Extended Health Care and/or Dental Care benefits under another group insurance plan please complete this section.

Extended Health Care	☐ None	☐ Single	☐ Family	☐ Couple	☐ Single Parent	Spouse's Insurance Company:
Dental	☐ None	☐ Single	☐ Family	☐ Couple	☐ Single Parent	Spouse's Employer:

6 Spouse and Dependent Details. To be completed by Plan Member, if applicable.

Last Name	First Name	Gender	Date of Birth	Student	Disabled Dependent
Spouse		☐ Male ☐ Female	DD/MM/YYYY	**N/A**	**N/A**
Child		☐ Male ☐ Female	DD/MM/YYYY	☐ Yes ☐ No	☐ Yes ☐ No
Child		☐ Male ☐ Female	DD/MM/YYYY	☐ Yes ☐ No	☐ Yes ☐ No
Child		☐ Male ☐ Female	DD/MM/YYYY	☐ Yes ☐ No	☐ Yes ☐ No
Child		☐ Male ☐ Female	DD/MM/YYYY	☐ Yes ☐ No	☐ Yes ☐ No

- If you have more than 4 dependents, please attach a separate listing.
- If a child is over 21, indicate whether they are a student or disabled. For students, attach proof of schooling.

7 Beneficiary Designation. To be completed by Plan Member.

The plan member is the beneficiary of insurance on the lives of his or her dependents. Unless otherwise stipulated or prohibited by law, the designation is **Revocable**. If the beneficiary is shown as **Irrevocable**, his/her consent is required to change it. In Quebec the designation of your spouse (marriage or civil union) as beneficiary is Irrevocable unless otherwise specified.

Last Name	First Name	Relationship to Employee	Percentage of Benefit
			%
			%
			%

For Quebec Residents, if spouse is the beneficiary, the designation is: ☐ Revocable ☐ Irrevocable

Minor Clause. (Trustee for children under the Age of Majority)

Trustee name	Relationship to Life Insured

As indicated above the trustee is hereby appointed to receive any payment due on or after the life insured's death to any BENEFICIARY DESIGNATED on this form who is a minor on the date such payment(s) fall due.

8 Authorizations & Declarations. To be completed by Plan Member (sign and date in ink).

1. I designate the person(s) named above under Beneficiary Designation as beneficiary(s).
2. I declare that the information I have provided on this form is true and complete, and understand that if any of the information provided is incomplete or false my benefits may be terminated.
3. A photocopy or electronic version of this authorization is as valid as the original.
4. I certify that I am authorized to disclose and receive information about my Spouse and/or Dependents.
5. I authorize my Plan Administrator (HealthSource Plus) to use my social insurance number for tax reporting purposes and as an identification number where required for the administration of the plan.
6. I authorize my Plan Administrator (HealthSource Plus), its agents, insurers and service providers to use and exchange information collected in this form to underwrite, administer, determine eligibility and adjudicate claims.
7. I authorize my Plan Administrator (HealthSource Plus), Plan Sponsor as required, to use the information collected in this form to make any necessary payroll deductions which may be required.
8. I understand that the Plan Administrator shall have the right to recover from me any payments made in error.

Plan Member Signature	Date
	DD/MM/YYYY

9 Employer Authorization. To be completed by Plan Administrator.

I declare that the information provided on this form is complete and accurate to the best of my knowledge, and **I authorize** HealthSource Plus to use this information to administer the group benefits plan; obtain quotes for underwritten/insured products within the plan; verify the identity and eligibility of the plan member, spouse or eligible dependents; adjudicate and pay eligible claims; audit plan expenditures; and, prepare reports. **I understand** this information will only be provided to those insurers/adjudicators contracted by HealthSource Plus to provide services within the plan. **I declare** I have obtained the Consent of this Employee (and the consent of the spouse or partner where applicable) to provide this information to HealthSource Plus.

Name	Signature	Date
		DD/MM/YYYY

ABOUT YOUR PRIVACY: At HealthSource Plus, we recognize and respect the importance of privacy. Any information you provide us will be kept in a group life and health benefits file. We limit access to personal information to authorized staff or persons authorized by HealthSource Plus who require it to perform their duties, to persons you have granted access, and to persons authorized by law. We use the information you provide us for the administration, eligibility and adjudication of your benefits under your plan.