

GROUP ENROLMENT FORM- MCCA Members

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

1 EMPLOYER INFORMATION To be completed by Plan Administrator					INSTRUCTIONS GUIDE
Company Name MCCA	MCCA Centre #	Division Name	Class	Certificate Number	<p>Completed original forms should be saved in employee files.</p> <p>HSP will assume employee works 52 weeks per year – if this varies, please contact your Client Service Specialist</p>
Employee Hire/Reinstatement Date (dd/mm/yy)	Effective Date of Coverage (dd/mm/yy)	Is the waiting period being waived? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Salary \$	Number of regular hours worked per week?				
Salary Basis (check one): <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly <input type="checkbox"/> Annual		Employee Occupation			
2 EMPLOYEE INFORMATION To be completed by Employee					<p>Please print clearly, to ensure accurate entry of your information</p> <p>Include complete address including the postal code</p> <p>*MCCA Membership required to join plan.</p> <p>If you have questions on the type of coverage to select, please speak to your plan administrator.</p>
Employee Last Name		Employee First Name		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Date of Birth (dd/mm/yyyy)	Language Preference <input type="checkbox"/> English <input type="checkbox"/> French	Home Phone, including area code	MCCA Member <input type="checkbox"/> Yes <input type="checkbox"/> No	Individual Member #	
Street Address		Suite Number			
City	Province	Postal Code	Employee Email Address		
What type of coverage are you applying for? (check one) <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> None (please complete Section 5)					
3 FAMILY DETAILS To be completed by Employee, if applicable					<p>Please print clearly, to ensure accurate entry of your information.</p> <p>Please ensure all eligible dependent information is included at time of enrolment, to avoid delays in entry, or late applicant restrictions later.</p> <p>When providing school information for Overage Dependents, please ensure it clearly indicates dependent name, enrolment period, and confirmation of full-time enrolment status.</p>
Do you have a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No If common-law , when did you start living together? (dd/mm/yy)					
Last Name	Gender		Date of Birth (dd/mm/yy)		
First Name	<input type="checkbox"/> Male <input type="checkbox"/> Female				
Are any of your dependents OVER AGE DEPENDENTS? (over the maximum age for a child, as noted in your contract, and either disabled or enrolled in a full-time post secondary institute)					
If they are a student, please include current proof of full-time enrolment					
If they are disabled, please contact your plan administrator for the required forms for completion					
Child Last Name	Child First Name	Gender	Date of birth (dd/mm/yy)	Overage Student	Disabled
		<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4 COORDINATION OF BENEFITS To be completed by Employee, if applicable					<p>Coordination coverage may include spousal plan, alternate employer, etc.</p> <p>If an employee has coverage under two group plans, as the primary plan member, the plan with the earlier effective date will be first payer</p>
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	<input type="checkbox"/> None <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Couple <input type="checkbox"/> Single Parent				
Dental	<input type="checkbox"/> None <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Couple <input type="checkbox"/> Single Parent				

5 REFUSAL OF COVERAGE To be completed by Employee, if applicable.

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 am refusing coverage for:	HEALTH	DENTAL	Only health and dental coverage may be refused, if the employee and/or dependents have coverage elsewhere.
	<input type="checkbox"/> Myself & My Dependents <input type="checkbox"/> My Dependents only	<input type="checkbox"/> Myself & My Dependents <input type="checkbox"/> My Dependents only	

MUST ANSWER IF YOU ARE REFUSING HEALTH AND DENTAL COVERAGE:

Are you or your dependents now covered by any other group plan? Yes No

If yes: Policy holder's name: _____ Carrier _____

I understand that I am refusing insurance because myself and/or my dependents are insured under another applicable insurance plan.

Should I wish to join this plan at a later date, I understand that I must request enrollment within 31 days following the termination of other applicable insurance plan or approved life event.

If Dental coverage is refused, I understand that my benefits may be reduced if I later wish to enroll for this coverage.

I understand that I may be required to provide, at my expense, evidence of insurability satisfactory to the insurer, if later wish to enroll in any other coverage that is now being refused.

All other benefits are mandatory.

For any questions, please contact your Plan Administrator.

DATE OF REFUSAL

SIGNATURE IF REFUSING ANY COVERAGE

6 PRIMARY BENEFICIARY DESIGNATION To be completed by Employee.

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	Date of Birth (dd/mm/yy)	Relationship to Employee	Percentage (must total %)	Revocable – Can be changed without the consent of the beneficiary
				%	
				%	

Irrevocable – Named beneficiary must sign off on any changes

If you are a resident of the province of Quebec and you name your legal spouse (married or civil union) as the beneficiary, this beneficiary will be irrevocable unless you check the revocable box Revocable Beneficiary

Minor Clause (Trustee for children under the Age of Majority. In Quebec, any amount payable to a minor beneficiary during his/her minority will be paid to the parent(s) or legal guardian on his/her behalf)

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.

7 CONTINGENT BENEFICIARY To be completed by Employee, if applicable.

If there are no surviving beneficiaries at the time of my death, I declare that the following contingent beneficiaries shall receive the proceeds. If there are no surviving contingent beneficiaries at the time of my death, the proceeds shall be paid to my estate. Unless specified otherwise, my contingent beneficiaries will apply to all my benefits. The designations you make on this form replace any prior beneficiary designations.

Last Name	First Name	Date of Birth	Relationship to Employee	Percentage of Benefit	Can be used as a secondary beneficiary designation in the event the original designated beneficiary predeceases the insured.
				%	
				%	

If you are a resident of the province of Quebec and you name your legal spouse (married or civil union) as the beneficiary, this beneficiary will be irrevocable unless you check the revocable box Revocable Beneficiary

8 Employee Signature for Beneficiary Designation

Name _____ Date _____

8 AUTHORIZATIONS & DECLARATIONS To be completed by Employee (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
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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
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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.

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