



**Enrolment Application**

<b>Employer Group</b>	
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**Instructions**

**Employee** Complete the entire application, front and back, except the employer section of this form.  
**Return your completed application to your employer within five days.**

**Employer** Review application and determine employee, spouse and dependent eligibility. Complete employer section.  
**Return to Health Benefits Administration.**

Last Name	First Name	M.I.	Birth date D M Y	Social Insurance Number
Address			Check One <input type="checkbox"/> Male <input type="checkbox"/> Female	Home Phone
City	Province	Postal Code	Date Hired D M Y	Work Phone
Employer	Occupation/Job Title		1 <sup>st</sup> Day of Denominational Employment	
If Transferring From Other Denominational Employment, Former Employer			Is Spouse Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is Spouse a Student? <input type="checkbox"/> Yes <input type="checkbox"/> No

**This Section Must Be Completed**  
**(If single indicate and disregard remainder of section.)**

Spouse's Employer		Spouse's Birth date D M Y		Spouse's Annual Salary (If requesting coverage for spouse)	
<b>Check One</b> <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	Spouse SIN		Other Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of Insurance
	Effective Date D M Y		Other Insurance Phone Number		Dependents Covered? <input type="checkbox"/> Yes <input type="checkbox"/> No

Relationship	List Eligible Family Members to be Enrolled	Birth date	School Attending Coverage limited to completion of undergraduate degree	Full -time Hrs.	Expected date of Graduation
	Last Name	First Name	D M Y		
<input type="checkbox"/> Husband <input type="checkbox"/> Wife					
<input type="checkbox"/> Son <input type="checkbox"/> Daughter					
<input type="checkbox"/> Son <input type="checkbox"/> Daughter					
<input type="checkbox"/> Son <input type="checkbox"/> Daughter					
<input type="checkbox"/> Son <input type="checkbox"/> Daughter					
<input type="checkbox"/> Son <input type="checkbox"/> Daughter					
<input type="checkbox"/> Son <input type="checkbox"/> Daughter					

Please Circle Type of Coverage Requested (See Over)

A B C D E F G H

Enclose necessary supporting documentation if you choose "C" or "G"

**If you selected "C" or "G", you must also include a copy of the most recent Notice of Assessment from Canada Revenue Agency as verification of your spouse's income, or a letter from their employer verifying their yearly income.**

# Eligibility Application

*Please read the options carefully and circle the type of coverage for which you qualify.*

**If your spouse is employed they must first be covered under the benefit plan offered by their own employer. If their income is lower than \$29,268 we will coordinate coverage with their Plan for extended health and dental coverage at no additional cost to you. If their income is over \$29,268 and you wish to cover them under this Plan there is a monthly cost. Please review the options below to determine which option A - H is applicable to your family. Option H "Spouse Buy-In" provides extended health and dental coverage.**

**A. Coverage for Myself Only**

I do not request coverage for my spouse and/or my spouse is denominationally employed by \_\_\_\_\_.

**B. Full Family Coverage, Spouse Unemployed**

My spouse is unemployed and I wish full coverage for my spouse and eligible dependent children.

**C. Full Family Coverage**

My spouse earns less than the \$29,268, and has no health care coverage available through his/her employer. I understand that my spouse is eligible for health care assistance at no additional cost.

**D. Me and Full/Partial Coverage for my Dependent Children**

My spouse earns more than the \$29,268, and has health care coverage available for him/herself and our dependent children. I request health care coverage for our dependent children. There is no spouse coverage.

**E. Me and Full Dependent Children Coverage**

I am a single parent, and I request full health care coverage for me and my dependent children.

**F. Me and My Dependent Children, No Spouse Coverage**

My spouse earns more than the \$29,268, and has health care coverage available. My spouse will receive no health care benefits from my employer.

**G. Coordinated Coverage**

My spouse earns less than the \$29,268, and has limited health coverage through his/her employer as noted on the front of this application. Benefits should be coordinated with his/her health care plan. I understand that my spouse is eligible for health care assistance at no additional cost for health care expenses not covered by his/her health care plan.

**H. Buy-in Provision Spouse Only**

My spouse earns more than the \$29,268, and has no access to health care assistance through his/her employer. I would like to "buy-in" to the HBP. I understand my payroll deduction for his/her coverage will be \$181.00 per month (may change annually).

## Authorization and Certification

I authorize all providers of health care to furnish all records pertaining to medical history, services rendered and treatment given as pertains to evaluation of enrolment application and or claims. This authorization shall become effective immediately and shall remain in effect as long as necessary to enable Health Benefits Administration to process my application and/or claims.

I understand that the above coverage accommodation will remain in effect until termination of my employment. **I further agree to notify my employer of any changes in my family status of the eligibility of my spouse. Failure to notify HBA of any status change will authorize HBA to deny payments of future claims and ask for collection of past paid claims for ineligible spouse or dependents.**

I certify that all the above information is complete and correct.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date Signed

## Office Use Only

**Employer please return enrolment application to Health Benefits Administration**

Enrolment Data		
<input type="checkbox"/> Date Entered	<input type="checkbox"/> Out of Country Card	<input type="checkbox"/> MedCat Buy-In
<input type="checkbox"/> RX card	<input type="checkbox"/> Buy-in option for spouse	Salary \$
<input type="checkbox"/> Additional RX Plus Card for over-age student. Name	Coverage Effective D      M      Y	
Signature	Title	Date D      M      Y