



Enrolment Application

Employer Group	
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Instructions

Employee

Complete the entire application, front and back, except the employer section of this form.
Return your original completed application to your employer within five days. (an email, photocopy or fax is not acceptable)

Employer

Review application and determine employee, spouse and dependent eligibility. Complete employer section.
Return to Health Benefits Administration. (an email, photocopy or fax is not acceptable)

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 st 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 <small>(If requesting coverage for spouse, please send statement of gross income)</small>		
Check One <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Spouse SIN		Other Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of Insurance		Policy #	
	Effective Date D M Y		Other Insurance Phone Number			Dependents Covered? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do You Have Provincial Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does Your Spouse Have Provincial Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			Your Email Address			

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 your spouse's most recent Notice of Assessment from Canada Revenue Agency as verification of your spouse's income OR a letter from their employer verifying their total yearly gross 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 \$35,000 we will coordinate coverage with their Plan for extended health and dental coverage at no additional cost to you. If their income is over \$35,000 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 \$35,000 (**a statement of gross income is required**), 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. *To avoid delays on your enrolment application, you must also include a copy of your spouse's most recent Notice of Assessment from Canada Revenue Agency as verification of your spouse's income OR a letter from their employer verifying their total yearly gross income.*

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

My spouse earns more than the \$35,000, 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 \$35,000, 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 \$35,000, 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. *To avoid delays on your enrolment application, you must also include a copy of your spouse's most recent Notice of Assessment from Canada Revenue Agency as verification of your spouse's income OR a letter from their employer verifying their total yearly gross income.*

H. Buy-in Provision Spouse Only

My spouse earns more than the \$35,000, 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 \$244.00 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