Health Benefits Administration
Seventh-day Adventist Church in Canada
1148 King Street East, Oshawa, ON L1H 1H8
Telephone 1-800-263-7868 or 905-433-3964 • **Fax** 905-433-3717

Enrolment Application

Employer Group	

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 ❑ Male ❑ Female	Home Phone
City	Province / Postal Code		Date Hired D M Y	Work Phone
Employer	Occupation/Job Title		1st Day of Denominational Employment	
If Transferring From Other Denominational Employment, Former Employer			Is Spouse Employed? ❑ Yes ❑ No	Is Spouse a Student? ❑ Yes ❑ 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, please send statement of gross income)

Check One ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed	Spouse SIN	Other Insurance? ❑ Yes ❑ No	Name of Insurance	Policy #
	Effective Date D M Y	Other Insurance Phone Number		Dependents Covered? ❑ Yes ❑ 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			
❑ Husband ❑ Wife								
❑ Son ❑ Daughter								
❑ Son ❑ Daughter								
❑ Son ❑ Daughter								
❑ Son ❑ Daughter								
❑ Son ❑ Daughter								
❑ Son ❑ 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 $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.

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.

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 $219.00 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		
❑ Date Entered	❑ Out of Country Card	❑ MedCat Buy-In
❑ RX card	❑ Buy-in option for spouse	Salary $
❑ Additional RX Plus Card for over-age student. Name		Coverage Effective D M Y
Signature	Title	Date D M Y