



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 by mail. (an email, photocopy or fax is not acceptable).
The employee must be enrolled within 31 days of the date of eligibility or must pass a medical to be added to benefits as a late enrollee.

Last Name		First Name		M.I.	Birth date D M Y			Social Insurance Number			
Complete Mailing Address					Check One <input type="checkbox"/> Male <input type="checkbox"/> Female			Cell Phone			
City		Province		Postal Code		Date Hired D M Y			Work Phone		
Employer		Occupation/Job Title			If Transferring From Other Denominational Employment: Former Employer						
Do You Have Any Valid Canadian Provincial Health Card? <input type="checkbox"/> Yes <input type="checkbox"/> No				Does Your Child(ren) Have Any Valid Canadian Provincial Health Card? <input type="checkbox"/> Yes <input type="checkbox"/> No				Your Email Address			
This Section Must Be Completed (If single indicate and disregard remainder of section.)											
Spouse's Birth date D M Y			Does Your Spouse Have Any Valid Canadian Provincial Health Card? <input type="checkbox"/> Yes <input type="checkbox"/> No				Is Spouse a Student? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is Spouse Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Spouse's Employer				Spouse's Annual Salary (If requesting coverage for spouse, please send statement of gross income)							
Check One <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Does Your Spouse Have Health Benefits From Employer <input type="checkbox"/> Yes <input type="checkbox"/> No				Name of Insurance					
		Policy #		Effective Date D M Y			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 first 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

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.

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 (they may not opt out of that coverage). If their income is lower than \$46,000, we will coordinate coverage with their Plan for extended health and dental coverage at no additional cost to you. If their income is over \$46,000 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 \$46,000 (to avoid delays on your enrolment application, **you must include a copy of your spouse's most recent Notice of Assessment from Canada Revenue Agency as verification of your spouse's income**) 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 \$46,000 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 \$46,000 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 \$46,000 (to avoid delays on your enrolment application, **you must include a copy of your spouse's most recent Notice of Assessment from Canada Revenue Agency as verification of your spouse's income**) 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

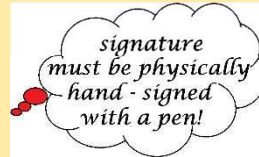
My spouse earns more than the \$46,000 and has no access to health care assistance through his/her employer. I would like to "buy-in" to the HBP. I understand my payroll deduction for his/her coverage will be \$144.50 per month (may change annually) **for a minimum of 1 year.**

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