CANADIAN COUNCIL of CHRISTIAN CHARITIES

Canadian Benefit Administrators Ltd.

EMPLOYEE APPLICATION FOR GROUP COVERAGE

****All sections must be completed for processing**

Employer Information

This section is to be completed by the plan administrator

○ New Enrolment ○ Reinstatement of Coverage ○ Change in Coverage (YY/MM/DD):_____

Employer: _____ Division number: _____

Are you a Canadian Citizen or Landed Immigrant? ○ Yes ○ No

Cert #: _____Province of residence: _____ Province of employment: _____

Date of full-time employment/reinstatement: Year: _____ Month: _____ Day: _____

Earnings: _____ per ○ year ○ month ○ week ○ hourly

Occupation: _____ Schedule hours/week: _____

Employee Information

This section is to be completed by the employee

Please print clearly, in BLUE INK

Employee: _____
last name first name middle initial

○ Male ○ Female Smoker: ○No ○Yes Date of Birth: Year _____ Month _____ Day _____

Employee
Street address:_____

City: _____ Province: _____ Postal Code: _____

Do you have a spouse? ○ No ○ Yes

Common law spouse? ○ No ○ Yes Date of co-habitation _____

Do you have other dependents, which includes children/students/disabled persons? ○ Yes ○ No

Requested Coverage

This section is to be completed by the employee.

Health, dental and/or vision coverage may only be removed if you have duplicate group benefits through your spouse's employer.

I understand the group benefits offered to me: ○ I wish to Apply for: ○ I Decline to participate in:

Healthcare for ○ myself ○ myself and my dependents ○ I refuse coverage

Dentalcare for ○ myself ○ myself and my dependents ○ I refuse coverage

Note: Coverage can only be refused if you and your dependents are covered by duplicate group benefits through your spouse's employer.

Spousal insurer's name: _____ Plan number: _____

If your spouse loses coverage you must apply for coverage within 31 days of loss of such coverage. If you do not apply within 31 days you and your dependents may be required to provide acceptable proof of your insurability to be covered. If you are approved, dental benefits, if applicable, may be limited. ***Please see your plan administrator for details.***

Family Information

This section is to be completed by the employee.

Complete this section only if you have requested dependent coverage above. Please print clearly, in BLUE INK.

○ **Spouse**

○**Common Law - Date of co-habitation** _____

_____
last name first name middle initial

Date of birth
Year _____ Month _____ Day _____

Gender
○ Male ○ Female

What group benefits coverage does your spouse/common law spouse have through their employer?

DENTAL Single ○ Family ○ Waived ○ None ○

HEALTH Single ○ Family ○ Waived ○ None ○

VISION Single ○ Family ○ Waived ○ None ○

Complete this section only if you have requested dependent coverage above. If there are more than 4 dependents, please attach a separate list. Please print clearly, in BLUE INK.

Child/ren Information			Date of birth	Gender		Full time student		Disabled dependent	
			Year/Month/Day	Male	Female	Yes	No	Yes	No
last name	first name	middle initial	_____/_____/_____	○	○	○	○	○	○
last name	first name	middle initial	_____/_____/_____	○	○	○	○	○	○
last name	first name	middle initial	_____/_____/_____	○	○	○	○	○	○
last name	first name	middle initial	_____/_____/_____	○	○	○	○	○	○

For Over Age Student (students over age 21) please attach copy of student card. Until proof of student status is received, over age dependents will not be covered.

Beneficiary Designation

This section is to be completed by the employee.

The original copy of this form will be required for a life claim.

If a beneficiary is not assigned "ESTATE" will be assumed

Please print clearly, in BLUE INK.

Beneficiary's Name(s)			Percent allocated	Relationship to Employee
last name	first name	middle initial		
last name	first name	middle initial		
last name	first name	middle initial		

You must make your beneficiary designation revocable or irrevocable by checking one of the circles below. You may change a revocable beneficiary designation at any time. You may not change an irrevocable beneficiary designation or make certain changes to your plan without the written consent of the irrevocable beneficiary.

Note: Where Québec law applies and you have designated your married spouse or civil union spouse as beneficiary, the designation will be irrevocable unless you check the circle marked "Revocable" below.

I hereby make the above beneficiary designation: ○ **Revocable** ○ **Irrevocable**

If you are designating a trustee/administrator, we recommend you consult with a legal advisor, and with any proposed trustee/administrator.

I designate the person(s) names above under Beneficiary Designation as my beneficiary. I certify that the information in this form is true and complete, to the best of my knowledge. If applying for benefits for my dependents, I am authorized to release information concerning my spouse/common law spouse and my dependents for the purpose of determining their eligibility for benefits. If my social insurance number is used as my certificate number, I authorize use for the identification and administration of my group benefits. I authorize Canadian Benefit Administrators to make any and all inquiries relating to group benefits claims and administration on behalf of my dependents and myself.

Once completed, submit to:
Canadian Benefit Administrators
930 The East Mall
Etobicoke, Ontario M9B 6J9

_____ _____

Employee Signature Date