ELCIC Group Services Inc.

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GROUP BENEFITS PLAN ENROLLMENT FORM

Benefits include Life Insurance, Long Term Disability, Accidental Death & Dismemberment and Extended Health and Dental Insurance.
Details of coverage can be found on the Group Services website.

Member Information:

Name:	*Last*	*First*	*Initial*	Member Number: *(if known)*	

Beneficiary Appointment for Life Insurance

Must be a Canadian resident at time of payment, otherwise benefit amount will be paid to member's estate.

Last Name	First Name	Birth Date: *(d/m/y)* (If minor, complete Trustee Appointment)	Address (If different from member)	Relationship	S.I.N.	% Share*

If more space is required, provide information on reverse. ** (Must equal 100%)*

Trustee Appointment for Minors

_____ , _____ **of** _____ ,
First, Initial, Last Name ***Relationship*** ***Address***

If living shall be and is hereby appointed trustee to receive and disburse any monies payable hereunder to such child(ren) aforesaid during minority, or failing such trustee, to the duly appointed guardian of such minor child(ren) as trustee. Payment so made to said trustee shall discharge the payer to the extent of such payment.

Extended Health and Dental Plan Options

Does your spouse have extended health and/or dental benefits through his/her current employer that includes coverage for you and your dependents?

◯ **YES** ◯ **NO**

If "**YES**", you must select one of the following options:

A. You may **WAIVE** your extended health and/or dental coverage. If at any time your spouse loses his/her extended health and/or dental coverage, you must enroll for coverage of these benefits under your true family status.

B. You may **CO-ORDINATE** your extended health and/or dental benefits with those of your spouse. Co-ordination of benefits allows for reimbursement of insured medical and dental expenses from both yours and your spouse's plans, up to a total of 100% of the actual expense incurred.

Authorization

A. I wish to **WAIVE** the following benefits: ☐ Extended Health ☐ Dental
(*A letter from your spouse's employer confirming your coverage under his/her plans must be attached to this completed form.)*

OR

B. I wish to **CO-ORDINATE** the following benefits with those of my spouse: ☐ Extended Health ☐ Dental

Effective Date of Spouse's Coverage: *(d/m/y)* _____ Spouse's Insurance Carrier: _____

Spouse's Group/Plan #: _____ Spouse's Plan Member/Certificate #: _____

NEW TO CANADA - Please indicate the effective date of your provincial health coverage: *(d/m/y)* _____ *

**Note: Your extended health benefit under the group benefits plan will start effective as of this date.*

I certify that all information contained hereon is correct. I request my employer to arrange for the issuance of group coverage for which I am eligible. I understand that if I have eligible dependents I will automatically be enrolled with family coverage. I authorize my employer to deduct from my earnings the contributions, if any, required for the coverage.

I consent to the information provided here being collected, used and disclosed by ELCIC Group Services Inc. (GSI) for purposes of activities related to the efficient administration of my entitlements under the benefits plan. I consent to GSI disclosing and/or obtaining information to and from its agents and services providers, including, but not limited to insurers, benefits providers or administrators and benefits consultants.

If applying for benefits for my dependents, I am authorized to release information concerning my spouse and my dependents.

I understand that I have the right to access the personal information in my file, and if necessary, correct any inaccurate information.

Employee's Signature _____ **Date** _____
Day ***Month*** ***Year***

Employer's Signature _____ **Date** _____
Day ***Month*** ***Year***

Title of Signer _____

Return completed form to ELCIC Group Services Inc.
We recognize and respect every individual's right to privacy. Refer to the GSI website for our complete Privacy Policy.