ELCIC Group Services Inc.

805-177 Lombard Ave. Winnipeg, MB R3B 0W5
T: 204-984-9181 **F:** 204-984-9179 **Toll Free:** 1-877-ELCICGS (352-4247) **Email:** info@elcicgsi.ca **Website:** www.elcicgsi.ca

ELIGIBILITY FORM

Eligibility and Enrollment Requirements

Eligibility criteria for Rostered employees:
Pension and Group Benefits Plans - salary is at least 25% of the Year's Maximum Pensionable Earnings ("YMPE")
please refer to the GSI website for the current year's amount
Eligibility criteria for non-Rostered employees:
Pension plan - salary is at least 25% of the YMPE
Group Benefits Plan - salary is at least 25% of YMPE and the employee must work an average of 20 hours/week or more.

All employees of ELCIC employers who meet the eligibility criteria are required to enroll, unless waiving as described below.

Waiving Enrollment
Pension plan enrollment may be waived by a non-Rostered employee (except if residing in Manitoba, call GSI for more information) if eligibility requirements are met, but the employee is working on average less than 30 hours per week. A waiver form must be signed and the employer must ensure that an eligible employee, who has waived joining the pension plan, is notified of their eligibility at least annually.

Health & dental coverage may be waived if the employee is covered under their spouse's employer sponsored health & dental plan. In this case, proof of coverage in a spousal plan (ie: letter from spouse's employer) is required in order to waive coverage.

Enrollment Date
The enrollment date for all eligible employees (both Rostered and non-Rostered) is their date of hire or the date the employee first became eligible.

Employer – Please Complete this Section

Employer Name:		Employer Number:	
Office Address:	*Address*	*City & Province*	*Postal Code*
Employee Name:	*Last*	*First*	Member Number: *(if known)*
Is Annual Salary expected to be at least 25% YMPE	Yes No	Hire Date: *(d/m/y)*	
Complete for Non-Rostered employees only:			
Occupation:		Average # of hours worked per week	

Employer - Authorization

I certify that all information contained above is correct.

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

Title of Signer ______________________

Note: If eligible, please have employee complete page 2 on reverse

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Employee Data

Member Information: Employee – Please Complete this Section

Name:	*Last*		*First*		*Initial*
Home Address:	*Address*	*City & Province*			*Postal Code*
Gender:	Male Female	Birth Date: *(d/m/y)*		Home Phone:	
Personal E-mail address:				Mobile Phone:	
Marital Status: *(Married, common-law, separated, single)*		Date of Marriage/ Co-habitation: *(d/m/y)*		S.I.N.:	
Spouse's Name:	*Last*		*First*		*Initial*
Gender:	Male Female	Birth Date: *(d/m/y)*		S.I.N.:	

Dependent Child(ren) Information

Last Name	First Name	Gender *(M/F)*	Date of Birth *(d/m/y)*	If over age 21 is child a student?

Spouse – The person to whom you are legally married; or a person continuously living with you in a role like that of a marriage partner for at least one year.

Dependent Child/ Children – Your natural or legally adopted child (dependent on you or your spouse for financial support), or a stepchild, who is: unmarried; under age 21, or under age 25 if a full-time student; not employed on a full-time basis; and not eligible for insurance as an employee under this or any other group benefit program.

Employee's Signature ____________________ **Date** ____________________

Day *Month* *Year*