Please send original, signed copy to:

D A T O W N L E Y

HOURBANK ENROLLMENT FORM FOR POLICY # 29243 – BASIC PLAN

Employee Enrolment Form for Group Insurance

- Complete this form on date of hire for a New Plan Member. Part 4 must be completed.
- To submit, MAIL the ORIGINAL completed form to the BCCA Employee Benefits office.
- You can fax the form for immediate processing, but the original must follow.
- Keep a copy of this form with the Plan Member's personnel file.

REASON FOR COMPLETION
New Plan Member
Re-hire Plan Member – previous plan term date (M/D/Y)_______/_____/_____

Part 1: Employee & Basic Insurance Information

Employer Group Name		Do you have provincial health coverage? Yes No
Employee's Last Name / First Name / Initial	SIN	Payroll ID#
Street (Mailing) Address / Birth date (M/D/Y) _____/_____/_____	Sex: Male Female	Family Status: Single Family
City / Province / Postal Code	Extended Health Coverage Required: Single Family Waived (*see Part 2*)	Dental Coverage Required: Single Family Waived (*see Part 2*)

If your spouse is common law, indicate the date of cohabitation(M/D/Y)________/_____/_____

Definition of spouse: a person of the same or opposite sex who is either married to you or has been living with you for at least 12 months.

Dependent		Dependent's Last Name (if different from Employee)	First Name	Initial	Birth date (M/D/Y)	Relationship	Sex (M/F)	Provide name of school below if child is over 19 and studying full-time. If child is disabled to apply for coverage beyond age 19, indicate nature of disability and attach details.
01	Spouse							
02	1st child							
03	2nd child							
04	3rd child							

Part 2: Spousal or Other Coverage

Are you or your dependents covered for extended health and/or dental benefits by another plan:	Benefit	Name of Carrier	Group Number	Certificate ID#	Coverage
	Dental:				Single Family
Yes (specify) No	Health:				Single Family

Part 3: Beneficiary Designation and Authorization

Last Name	First Name	Initial	Share of Proceeds (%)	Relationship to Employee	Name of Trustee for Beneficiaries Under the Age of Majority (19 in B.C.)	If a resident of Quebec * (please indicate)
						Revocable Irrevocable
						Revocable Irrevocable
						Revocable Irrevocable

To apply for Optional Life and/or Voluntary AD&D, please complete the separate application forms for these benefits. You will need to designate a separate beneficiary for each of these benefits on the applicable form.
*Where Quebec laws apply, a spouse beneficiary is irrevocable unless you make the designation revocable. An irrevocable beneficiary designation cannot be changed without the written consent of the irrevocable beneficiary.
I consent to the collection, use, and exchange of my personal information by my plan sponsor, the administration of my retirement, savings, and other group benefits programs, the agents retained by my plan sponsor of the administrator, the insurance company providing benefits, and/or other person who requires information for the purpose of retirement, savings or other group benefits plan administration. I authorize these parties to obtain, and exchange between them, any information about me, my spouse, or my dependent children that they require for the purposes of determining my benefit entitlements, and for record-keeping, file identification, reporting, underwriting, procurement of health information, claims adjudication and resolution, program management, and other services provided to me and my plan sponsor from time to time. I confirm that I have obtained the consent required of my spouse and any dependent children over the age of majority to permit me to give the above consent as it relates to their personal information. I hereby confirm the above beneficiary designation, which replaces any previous revocable beneficiary. I reserve the right to change my revocable beneficiary designation at any time. I hereby apply for group insurance benefits under my plan sponsor's plan and authorize any required deductions. If I should receive a settlement from, or a judgement against, a liable third party for wage loss, extended health, or other benefits covered under my group plan, I agree and authorize the third party to reimburse the insurance company providing benefits up to the amount of benefits advanced to me pending such settlement or judgement. I consent to the use of my social insurance number for tax reporting purposes and as an identification number where it is required in the administration of the plan.
I understand that on the date my insurance becomes effective I must be actively at work. I also understand that on the date the insurance of my dependent(s) becomes effective that they cannot be confined to hospital. I certify that the information given above is true and complete.

Employee Signature____Date Signed (M/D/Y) /_ /_____

Part 4: For Plan Administrator/Employer Use Only (PLEASE COMPLETE ALL PARTS)

Employee's Occupation/Position	Date of Hire (M/D/Y)	Policy #	Div # (if applicable)	Class	
		29243			
			Effective Date (M/D/Y)	Authorized Signature (Plan Administrator)	
per					

Evidence of Insurability Checklist:
- Did the employee apply more than 31 days after first becoming eligible for Life and Disability coverage? No Yes
- Did the employee apply more than 4 months after first becoming eligible for Extended Health and Dental Care coverage? No Yes

If Yes to the above, employee must complete Evidence of Insurability form/Statement of Health for the applicable insurers. Please submit these to the BCCA Employee Benefits office for processing. Insurance does not take effect until you are notified of the approval. Attach approval letters to your copy of this form and keep on file. Benefit applications should be submitted within 31 days after the employee becomes eligible in order to avoid Evidence of Insurability requirements.