



## EMPLOYEE BENEFIT ENROLMENT/CHANGE FORM

**Instructions:** Please fill out all pertinent information below and forward to your Plan Administrator for processing.

Please Check One	Effective Date	End Date
<input type="checkbox"/> <b>New Employee</b>	dd/ mm/ yy / /	N/A
<input type="checkbox"/> <b>Existing Employee</b> (Change of information)	dd/ mm/ yy / /	N/A
<input type="checkbox"/> <b>Termination</b>	N/A	dd/ mm/ yy / /

### Plan Sponsor Information

Employer Company Name		Group Number <i>(office use)</i>	
Co-Insurance %	Deductible \$	Annual Maximum \$	
<b>Benefits will be prorated for balance of current plan year for new employees.</b>			

### Employee Information Please Print

Employee First Name		Middle Initial	Employee Last Name	
Address			Home Tele No:	Business Tele No:
City	Province	Postal Code	Date of Birth dd/ mm/ yy / /	

### Dependent Information Please Print

Dependents	First Name	Last Name	Date of Birth
<i>Spouse</i> (married or common law)			dd/ mm/ yy / /
<i>Dependent 1</i>			dd/ mm/ yy / /
<i>Dependent 2</i>			dd/ mm/ yy / /
<i>Dependent 3</i>			dd/ mm/ yy / /
<i>Dependent 4</i>			dd/ mm/ yy / /

**Note:** If you have more dependents, please fill out another form and submit with this form.



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### Direct Deposit

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	If "Yes", please attach void cheque
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### Authorizations *(Signatures are to be completed by all enrolled participants where applicable)*

I authorize release of any information requested in respect of the claim to AccertaClaim Servcorp Inc. or its agents and certify that the information given is accurate and complete to the best of my knowledge. I authorize its use for the identification and administration of my group benefits. As the signee, I am the participant who has reached the age of consent (16 years and over) or the guardian for the participant who has not reached the age of consent (under 16 years of age).

Employee _____	Date _____
Spouse _____ (Married or Common Law)	Date _____
Dependent _____	Date _____
Dependent _____	Date _____
Dependent _____	Date _____
Dependent _____	Date _____

As the Benefits Administrator, I have reviewed the completed information. I hereby certify the eligibility of this authorized participant(s) to receive benefits.

Plan Administrator _____	Date _____
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