Grandeur Group Benefits

GROUP ENROLMENT FORM

EMPLOYMENT INFORMATION [TO BE COMPLETED BY YOUR PLAN ADMINISTRATOR] – COMPLETE ALL SECTIONS

GROUP NAME [EMPLOYER]	DIVISION	CLASS	CLIENT ID [LEAVE BLANK]

MEMBER DATE OF HIRE/RE-INSTATEMENT [MM/DD/YYYY]	SALARY [ANNUAL]	NUMBER OF HRS WORKED PER WEEK

SALARY TYPE ☐ hourly ☐ monthly ☐ bi-weekly ☐ semi-monthly ☐ annual	OCCUPATION

APPLY WAITING PERIOD ☐ YES ☐ NO [IF NO PLEASE PROVIDE REASON FOR WAIVING THE WAITING PERIOD]

EMPLOYEE INFORMATION [PLAN AND IDENTIFICATION NUMBERS ARE ASSIGNED ONCE ENROLMENT IS COMPLETED]

EMPLOYEE LAST NAME	EMPLOYEE FIRST NAME	GENDER ☐ Male ☐ Female

DATE OF BIRTH [MM/DD/YYYY]	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ COMMON LAW

ADDRESS	CITY	PROVINCE	POSTAL CODE

PHONE [INCLUDE AREA CODE]	E:MAIL	LANGUAGE ☐ English ☐ French

DEPENDENT COVERAGE REQUIRED ☐ Yes ☐ No	IF NO PLEASE SPECIFY REASON	PLEASE INDICATE IF DRUG/DENTAL CARDS(S) ARE NEEDED FOR CHILDREN ☐ YES ☐ NO

RELATIONSHIP	LAST NAME	FIRST NAME	GENDER	DATE OF BIRTH [MM/DD/YYYY]	STUDENT	DISABLED DEPENDENT
SPOUSE			☐ Male ☐ Female		☐ Yes ☐ No	☐ Yes ☐ No
CHILD			☐ Male ☐ Female		☐ Yes ☐ No	☐ Yes ☐ No
CHILD			☐ Male ☐ Female		☐ Yes ☐ No	☐ Yes ☐ No
CHILD			☐ Male ☐ Female		☐ Yes ☐ No	☐ Yes ☐ No
CHILD			☐ Male ☐ Female		☐ Yes ☐ No	☐ Yes ☐ No

If you or your spouse are covered for extended health care and/or dental care benefits by another plan please indicate coverage type						
	Extended Health	☐ None	☐ Single	☐ Couple	☐ Family	☐ Single Parent
	Dental	☐ None	☐ Single	☐ Couple	☐ Family	☐ Single Parent

NAME OF SPOUSE'S EMPLOYER	NAME OF SPOUSE'S INSURANCE COMPANY	POLICY/PLAN NUMBER

REFUSAL OF EXTENDED HEALTH AND DENTAL BENEFITS

If You Or Your Dependents Are Presently Covered For Extended Health And/Or Dental Benefits Under Another Group Insurance Program You May Refuse Coverage By Selecting The Appropriate Boxes

I Refuse Coverage For Myself, My Spouse And My Dependents	☐ Extended Health	☐ Dental
I Refuse Coverage For My Spouse And Dependents	☐ Extended Health	☐ Dental

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BENEFICIARY INFORMATION – ALL INFORMATION IS REQUIRED

I hereby assign the following individual(s) as my beneficiary. Your beneficiary will automatically default to your "ESTATE" if you fail to complete this section. Unless Otherwise Stipulated Or Prohibited By Law, The Designation Is Revocable. If The Beneficiary Is Shown As Irrevocable, His/Her consent is required to change it.

LAST NAME	FIRST NAME	DATE OF BIRTH [MM/DD/YYYY]	RELATIONSHIP STATUS	PERCENTAGE [MUST TOTAL 100%]

If you name an irrevocable beneficiary and wish to change it at a later date, the current beneficiary would be required to approve the change.

- ☐ **REVOCABLE**
- ☐ **IRREVOCABLE**

Note: If beneficiary is shown as irrevocable, his/her consent is required to change it. Include a signed and dated consent with this form. **You are responsible for ensuring the validity of your designation.**

FOR QUEBEC RESIDENTS ONLY - In Quebec, the designation of your spouse as beneficiary is irrevocable unless otherwise specified. If spouse is beneficiary, designated is:

- ☐ **REVOCABLE**
- ☐ **IRREVOCABLE**

TRUSTEE DESIGNATION: This section is to be completed only if the beneficiary designated above is under the age of majority

TRUSTEE NAME [Trustee to receive any amount due to any beneficiary under the age of 18]	**RELATIONSHIP STATUS**

DECLARATION & AUTHORIZATION – MUST SIGN AND DATE

I disclose the person name(s) under Beneficiary Designation as the appointed Beneficiary (s). I confirm that the information provided on this form is true and complete, and understand that if any of the information is incomplete or false my benefits can be terminated. I acknowledge that I am authorized to disclose and receive information about my spouse and/or dependents. the Plan Administrator, its agents, insurers and service providers are authorized to use and exchange information on this form to underwrite, administer, determine eligibility and adjudicate claims. I understand that Personal Information collected with this Application for Insurance is confidential and will not be used or any purpose other than in conjunction with this request form, and subsequent administration of, the Group Insurance protection that is afforded to Applicants, Spouses, and Dependent Children under this plan. I authorize the Plan Administrator to recover any payments made in error.

APPLICANT'S SIGNATURE: **DATED:**

PRIVACY & CONFIDENTIALITY

We protect our Customers' confidential information. A combination of industry, legislated and our own corporate privacy and confidentiality requirements govern the level of detail shared about any plan member and his or her dependents' benefits. In terms of telephone inquiries to the Plan Administrator, Customer Service, the information provided varies based on the relationship of the person making the inquiry to the insured (e.g. plan administrator, plan member or dependent). After the caller has been screened for appropriate identification, only the information pertaining to the specific claim or treatment in question is shared.

EMPLOYER AUTHORIZATION – MUST SIGN AND DATE

I declare that the information provided above is accurate and true, and hereby authorize the Plan Administrator to use this information to administer the Group Benefits; obtain quotes for underwritten/insured products within the plan; verify the identity and eligibility of the plan member, spouse or eligible dependents; adjudicate and pay eligible claims; audit plans and prepare reports. I understand that this information will only be provided to those insurers affiliated with the Plan Administrator and acknowledge that I have obtained the consent of this Employee and Spouse/Partner to provide this information.

EMPLOYER'S SIGNATURE: **DATED:**

PO Box 41175 – 4141 Dixie Road | Mississauga | ON | Canada | L4W 5C9 |
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