

**Company Name**



**Employee Statement - To be completed in full by the Employee:**

Last Name	First Name	Middle Name	Name Commonly Used
Apt. # / House #	Street	City/Town	Province      Postal Code

**Enrollment Card**

**Please print in ink.  
To avoid delays ensure  
all areas are completed  
in full.**

<b>Date of Birth</b> _____/_____/_____ yyyy / mm / dd	<b>Provincial Health Care</b> Are you covered by the Provincial Health Care Plan?  <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Marital Status</b>  <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Common-law* <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	*If common-law is selected, the following is required: I have been living with and representing: _____ (common-law spouse's name) as my common-law spouse since: _____ yyyy / mm / dd Children of common-law spouse must reside with you to be eligible.
<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female			

<b>Health &amp; Dental Coverage</b>  <input type="checkbox"/> Single <input type="checkbox"/> Family/Couple <input type="checkbox"/> Waived**	** Coverage for Health & Dental may be waived if you have coverage under your spouse's group plan and the insurer information is provided: <b>Spouse's Insurance Company Name:</b> _____ If spousal coverage terminates, contact your Plan Administrator within 31 days to apply for Health & Dental coverage under this plan. After 31 days, proof of good health may be required and dental benefits may be restricted.
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**Dependent Information** When enrolling for dependent and/or family benefits, coverage will be considered **only** if the information below is complete. Please ensure spouse and each dependent child is listed regardless if they have Health & Dental coverage under another plan.

**Spouse**      Gender       Male       Female      Provincial Health Care in Place?  
Name \_\_\_\_\_ Date of Birth \_\_\_\_\_       Yes       No  
Last Name      First Name      yyyy / mm / dd

**Spouse's Coverage** Complete the following if your spouse has coverage through their employer's benefit program, please indicate who is covered for each benefit type:

Prescriptions     Spouse only     Spouse and you only     Spouse, you and dependent children     Spouse and dependent children     Dependent children only

Health Care       Spouse only       Spouse and you only       Spouse, you and dependent children       Spouse and dependent children       Dependent children only

Dental Care       Spouse only       Spouse and you only       Spouse, you and dependent children       Spouse and dependent children       Dependent children only

HSA               Spouse only       Spouse and you only       Spouse, you and dependent children       Spouse and dependent children       Dependent children only

Child's Last Name	Child's First Name	Gender M / F	Date of Birth yyyy / mm / dd	Relationship to Employee	Provincial Health Care in Place? Y / N	*** Full Time Student (age 22 - 25) Y / N	*** Coverage Disabled Dependent Y / N

\*\*\*See Plan Administrator for the applicable form.

**Primary Beneficiary** If no beneficiary is designated, the benefit will be assigned to the Estate. For additional beneficiaries see Plan Administrator for applicable form.

Last Name	First Name	Date of Birth (if minor) ****	Relationship	%
Last Name	First Name	Date of Birth (if minor) ****	Relationship	%

In Quebec, if you name your spouse as the beneficiary, this beneficiary will be irrevocable unless you check the revocable box.  Revocable beneficiary  
 A revocable nomination can be changed at any time without the beneficiary's consent. You cannot change an irrevocable beneficiary nomination unless certain requirements are met.

**Contingent Beneficiary** If the Primary Beneficiary predeceases me, I designate the following as my beneficiary:

Last Name	First Name	Date of Birth (if minor) ****	Relationship	%
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In Quebec, if you name your spouse as the beneficiary, this beneficiary will be irrevocable unless you check the revocable box.  Revocable beneficiary

\*\*\*\*If a minor beneficiary (under the Age of Majority by Province or Territory) has been designated please complete the following Trustee Designation:

**Trustee** I hereby appoint the individual named below, who is over the age of majority, as Trustee to receive and disperse monies payable under this group policy for any minor beneficiary:

Last Name	First Name	Relationship to Employee
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**Employee Authorization & Declaration - To be signed and dated by the Employee:**

groupSource understands that privacy is important. We recognize the sensitive nature of personal information and have taken the necessary measures to protect its confidentiality and proper use. Personal Information is information that can be used to explicitly identify an individual. When an employee applies for coverage, has a change in family status, job classification or earnings, personal information about that employee, their spouse and/or dependents may be collected. This information is used to verify eligibility, process claims accurately, provide accurate billing statements, satisfy the conditions for additional or optional coverage and perform insurance related functions. We do not collect, use or disclose personal information without consent, except where authorized by law. Only authorized personnel have access to your information. Personal information is not used for any purpose other than that for which it is collected. You can find more specific information regarding the collection and use of personal information in the Employee Benefits booklet, online at www.groupsource.ca or by writing directly to the Privacy Officer at groupSource, #400, 1550 - 5th Street SW Calgary, Alberta T2R 1K3.

I certify that all the information provided herein is complete and accurate. I hereby apply for group benefits coverage for which I am, or may become eligible. I confirm I am authorized to act on behalf of my spouse and/or dependents for the purpose of determining their eligibility for coverage. I acknowledge the use of my Social Insurance Number (SIN) for the purposes of tax reporting and authorize its use for identification and administration. I understand that the provision of my SIN for such purposes is optional and may be refused or withdrawn without affecting my benefit coverage. I agree to the terms and conditions of the group insurance contract(s) and authorize the regular payroll deduction of the required premium contributions. I have read the information above regarding privacy and hereby authorize my employer, groupSource, the Insurer(s) or their agents and any industry drug pooling entity, to collect, use, disclose and exchange all relevant information about me, my spouse or dependents required to: investigate and assess claims, detect and prevent fraud, compile statistical information to underwrite group risks on a prudent basis and comply with the law.

A copy of this authorization is as valid as the original. The original of this form is required for a Life Claim.

..... Employee Signature ..... Date Signed .....

**Employer Statement - To be completed in full by the Employer:**

Company Name		Policy #	Employee's Name	
_____		_____	Last _____ First _____	
Date of Hire	Occupation	Hours / Week	Class	Identification Number
yyyy / mm / dd	_____	_____	_____	# _____
				<input type="checkbox"/> Assigned by groupSource <input type="checkbox"/> Payroll <input type="checkbox"/> SIN

Earnings \$	Earnings Basis	OR <input type="checkbox"/> Commission or similar basis
	<input type="checkbox"/> Annual <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Hourly	For employees who earn commission or similar based pay, the earnings are calculated using the actual earnings in the preceding 2 calendar years based on T4 slips. This amount is to be pro-rated if less than 2 years' earnings are available. Year _____ T4 \$ _____ Year _____ T4 \$ _____

**Employer Declaration - To be signed and dated by the Employer:**

I certify that all the information provided herein is complete and accurate. I confirm that this employee has been continuously in our employ and is at present actively working with pay and applicable payroll deductions being made as per government regulations, since the date shown. I further confirm this employee is working the minimum number of hours as indicated in the policy.

..... Authorized Signature of Employer ..... Date Signed .....

**groupSource Use Only**  
 Effective Date \_\_\_\_\_ gS ID# \_\_\_\_\_ Class \_\_\_\_\_ Company # \_\_\_\_\_