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Employee Enrolment Form

Benecaid Office Use Only	
Effective Date	
Member ID	

1) To be completed by EMPLOYER

Company Name:				Group Number:
☐ New Application ☐ Re-instatement	Reason For Enrolment in Plan: ☐ Full-Time Hire		☐ Part-time Employee changed to Full Time	☐ Employee has lost Spousal Coverage
Permanent Date Employed: (dd/mm/yyyy)		Waive Benefits Waiting Period: ☐ Yes ☐ No	Hard copy of Benefit Booklet	☐ Yes ☐ No
Earnings: (Complete for Life/Disability) $	☐ Annually ☐ Hourly	Hours Worked Per Week:	Class:	Occupation:
Plan Administrator:	Name:	Signature:		Date Signed: (dd/mm/yyyy)

Permanent Date Employed: This is the date that the employee becomes eligible for the plan. Enrolment Forms must be received by Benecaid no later than 31 days following the employee becoming eligible to avoid being considered late. A late applicant may be subject to medical underwriting for themselves and their dependents. Benefits may be denied. **Employees and dependents must have provincial coverage.**
Waiving Waiting Period: The Benefits Waiting Period may be waived at the company discretion for key employees. Supporting documents may be requested.
Benefit Booklets: In an attempt to become more environmentally friendly, we will be providing employees with a hard copy of the benefits handbook only upon request for a cost of $2 per benefit booklet. All employees within your group will receive a drug/dental card.

2) To be completed by EMPLOYEE — EMPLOYEE INFORMATION

Last Name:	First Name:	Gender: ☐ Male ☐ Female		Date of Birth: (dd/mm/yyyy)
Street Address:	Unit #:	City:	Province:	Postal Code:
Telephone:	Email:			Do you have Provincial Coverage? ☐ Yes ☐ No

COORDINATION OF BENEFITS

Do you or any of your dependents have other coverage under another insurer? ☐ Yes ☐ No	Is the Coordination of Benefits: ☐ Health Single ☐ Health Family	☐ Dental Single ☐ Dental Family
If Yes, Please complete the following: Name of Insurer:		Policy Number:
If allowed under the plan, I elect to opt out of? ☐ Health ☐ Dental	Are you or any of your Dependents covered by Trillium (Ontario only): ☐ Yes ☐ No	If yes, who is the coverage for?

DEPENDENTS

Relationship	Last Name	First Name	Date of Birth (dd/mm/yyyy)	Provincial Coverage	Gender	*Student Age 21-24	**Disabled
Spouse				☐ Yes ☐ No	☐ Male ☐ Female	N/A	N/A
Child				☐ Yes ☐ No	☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No
Child				☐ Yes ☐ No	☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No
Child				☐ Yes ☐ No	☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No
Child				☐ Yes ☐ No	☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No

*Student: A dependent child age 21 through 24, attending an Institute of Higher Learning on a full-time basis, must provide proof of paid full-time student status for claims to be processed. Complete and return the Over-Age Dependent Eligibility Declaration Form to Benecaid which must be submitted each year/term.
**Disabled Dependent: A certificate confirming the dependent's disability must be provided to Benecaid.

BENEFICIARY (TO BE COMPLETED IF LIFE BENEFIT IS SELECTED)

Relationship	Last Name	First Name	Date of Birth: (dd/mm/yyyy)	%	Please check
					☐ Revocable ☐ Irrevocable
					☐ Revocable ☐ Irrevocable
					☐ Revocable ☐ Irrevocable

I designate _____, date of birth (dd/mm/yyyy) _____, as trustee/administrator to receive any amount due to any beneficiary under the age of majority (not applicable in Quebec). Receipt of these funds by the administrator/trustee constitutes a discharge for Benecaid.

SIGNATURE

Use of Your Information: The insurance you are applying for, or have been provided with, is underwritten by an insurer (the "Insurer") and is administered by Benecaid Health Benefit Solutions Inc. ("Benecaid"). You agree that Benecaid and the Insurer may collect, use and disclose your information as described in the enclosed Privacy Agreement. You agree that you will only provide information about your spouse or your dependent children, if each of them have authorized you to do so, and if each of them have consented to the collection, use and disclosure of his or her information as described in the enclosed Privacy Agreement. **Certification:** You certify the information you have provided is true, correct and to the best of your knowledge. **Communication:** You consent to Benecaid communicating with you via email. **Copies:** You agree that a photocopy or electronic copy of this section is as valid as the original.

Employee Signature:	Date Signed: (dd/mm/yyyy)

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Employee Enrolment Form Cont...

(Employee Name: _____)

6. PRIVACY AGREEMENT

In this Agreement, the words “you” and “your” mean any person who has requested from us, applied for, or is insured under any product or service offered, insured, reinsured, administered or sold by us. The words “we”, “us” and “our” mean

(1) Benecaid Health Benefit Solutions Inc. and Benecaid Insurance Solutions Inc. (collectively "Benecaid") and any affiliates of Benecaid. (2) any insurance company that insures your personal accident, sickness, life, travel, dental or other coverage provided through Benecaid; (3) any company that will in future provide coverage that replaces all or part of the insurance coverage listed in (2) or any other insurance currently provided through Benecaid; (4) any company that provides reinsurance to any company listed in (1) through (3); and (5) service providers for any company listed in (1) through (4).

The word “Information” means personal, health-related, financial and other details about you that you provide to us and we obtain from others outside our organization, including through the products and services you use.

You acknowledge, authorize and agree as follows:

COLLECTING YOUR INFORMATION

At the time you begin a relationship with us and during the course of our relationship, we may collect Information directly by us, or through our representatives, including:

- details about you and your background, including your name, address, date of birth, occupation and other identification, all of which are required under law;
- information you provide through the application and claims process for any of our insurance products or services; and
- information for the provision of insurance products and services.

This Information may be collected from you and from sources outside our organization, including from:

- government agencies and registries, law enforcement authorities and public records;
- any healthcare professional, medically-related facility, insurance company, or other person who has knowledge of; your information
- other service providers, agents, brokers and other organizations with whom you make arrangements; other insurance companies;
- your employer; references you have provided; and
- persons authorized to act on your behalf under a power of attorney or other legal authority.

You authorize those sources to give us the Information.

USING YOUR PERSONAL INFORMATION

This information may be used for the following purposes:

- to administer your insurance and your trust accounts (if any); to communicate with you;
- to verify your identity and investigate your personal background; to investigate, adjudicate, manage and coordinate your claims;
- to arrange and maintain insurance products and other services you may request; to help us better manage our business and your relationship with us;
- to evaluate and underwrite insurance risk, re-price medical expenses and negotiate payment of claims expenses;
- to better understand your insurance situation; to offer you products and services to meet your needs; to determine your eligibility for insurance and non-insurance products and services we offer;
- to detect and prevent fraud;
- to compile statistics; to help us better understand the current and future needs of our clients; and
- as required or permitted by law.

DISCLOSING YOUR INFORMATION

We may disclose your Information, including as follows:

- to other insurance companies, other financial institutions and health organizations;
- to any health-care professional, medically-related facility, insurance company or other person who has knowledge of your personal Information; to appropriate public health authorities.
- to administrators, service providers, reinsurers and prospective insurers and reinsurers of our insurance operations, as well as their administrators and service providers for these purposes;
- in response to a court order, search warrant or other demand or request, which we believe to be valid;
- to meet requests for information from regulators, including self-regulatory organizations of which we are a member or participant, to satisfy legal and regulatory requirements applicable to us;
- to our employees, suppliers, agents and other organizations that perform services for you or for us or on our behalf;
- when we buy or sell all or part of our businesses or when considering such transactions;
- to help us collect a debt or enforce an obligation owed to us by you; and
- where permitted by law.

Telephone discussions – When speaking with one of our telephone service representatives, we may monitor and/or record your telephone discussions for our mutual protection, to enhance customer service and to confirm our discussions with you.

MORE INFORMATION

Personal information or personal health information may be collected, used, disclosed, transferred, stored or processed outside of Canada and may therefore be subject to legal requirements in such foreign countries. Full details regarding how your privacy is protected can be obtained by asking us for a copy of our Privacy Policy.

Please read our Privacy Policy for further details about this Agreement and our privacy policies. Visit **www.benecaid.com** or contact us for a copy.

You acknowledge that we may amend this Agreement and our Privacy Policy from time to time to reflect changes in legislation or other issues that may arise. We will post the revised Agreement and Privacy Policy on our website listed above. You acknowledge, authorize and agree to be bound by such amendments.

If you wish to opt-out or withdraw your consent at any time for any of the opt-out choices described in this Agreement, you may do so by contacting us at: **1-877-797-7448**. Please read our Privacy Policy for further details about your opt-out choices.