



EMPLOYEE ENROLMENT FORM

- To submit change(s), make a photocopy of this form and send by FAX to the BSIA
- MAIL the original copy to the BSIA
- Make a photocopy of this form & keep it with the employee's personal file
- Section 1 of this form must be completed for all changes

BELOW FOR BSIA USE ONLY	
Insurance company/carrier name: Carrier A)	Policy/group contract number: A)
Green Shield Canada	
Carrier B)	B)
Manulife Financial	
Carrier C)	C)
Carrier D)	D)

Reason for completion:
<input type="radio"/> New Employee
<input type="radio"/> Re-hire Employee

TO BE COMPLETED BY EMPLOYER

① GROUP AND EMPLOYEE INFORMATION

Group name and division name/number		Hours worked/week	Occupation	Annual salary/earnings \$
Employee name (Last/First/Middle)		Sex <input type="radio"/> M <input type="radio"/> F	Family status <input type="radio"/> Single <input type="radio"/> Family	Birth date (dd/mm/yy)
Mailing address		City		Province Postal code
Date of hire/re-hire(dd/mm/yy)	Employee's class	Waiting period	Effective date (dd/mm/yy)	Employee ID number(s)

② EMPLOYEE COVERAGE AND FAMILY INFORMATION

Do you have comparable health and/or dental care coverage under your spouse's group insurance plan? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not applicable		If yes, indicate coverage <input type="radio"/> Health <input type="radio"/> Dental <input type="radio"/> Both Health & Dental		
Are you or your children covered under your spouse's plan? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Only I am covered <input type="radio"/> Not applicable		Policy number		
Required health and dental coverage <input type="radio"/> Single <input type="radio"/> Family <input type="radio"/> Waived*		Required dental coverage <input type="radio"/> Single <input type="radio"/> Family <input type="radio"/> Waived*		Do you require Dependent Life insurance? <input type="radio"/> Yes <input type="radio"/> No
Spouse/Child name (Last/First/Middle) <small>Spouse</small>	Birth date (dd/mm/yy)	Sex <input type="radio"/> M <input type="radio"/> F	Full-time student? N/A	Disabled dependent? N/A
Child		<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Child		<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Child		<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Child		<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

* If you are waiving health and dental coverage because you have comparable spousal coverage, you must complete a Waiver Form. You can ONLY waive health and dental coverage.

③ BENEFICIARY DESIGNATION – I designate as revocable beneficiary in the event of my death

Name of beneficiary for employee's basic life insurance (Last/First/Middle)	Share of proceeds %	Relationship to employee

Name of trustee for beneficiaries under age 18
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④ EMPLOYEE DECLARATION

I consent to the collection, use, and exchange of my personal information, including my Social Insurance Number, by my employer, the administrators of my retirement, savings, and other employee benefits programs, the agents retained by my employer or the administrator, an insurance company, and/or any other person who requires information for the purpose of retirement, savings, or other employee benefits plan administration. I authorize these parties to obtain, and exchange between them, any information about me, my spouse, or my minor children that they require for the purposes of determining my benefit entitlements, and for record-keeping, file identification, reporting, procurement of health information, claims resolution, program management, and other services provided to me and my employer from time to time. 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 employer's plan and authorize any required deductions.

TO BE COMPLETED BY EMPLOYEE

Employee signature

Date signed

, 20