CUPE 4207

GROUP BENEFITS ENROLLMENT FORM

Please read through this form carefully and complete all relevant sections.

2300 Yonge Street, Suite 3000, P.O. Box 2426, Toronto ON M4P 1E4

Canadian Benefits CONSULTING GROUP

SECTION I: PERSONAL INFORMATION

Your Last Name	**Your First Name**	**Employee Number/ID**	**Sex** (M or F)	**Date of Birth** (yyyy/mm/dd)

Your Address (Street Number and Name)	**City**	**Province**	**Postal Code**

Phone Number:	**Province of Residence (if different from above):**

Permanent Email Address:

Marital Status	Single	Married	Separated	Divorced	Common-Law	Widowed	If common-law, provide date cohabitation commenced (yyyy/mm/dd):

SECTION II: ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE (Optional)

I would like to enroll for AD&D:

	SINGLE	FAMILY
$100,000	☐ $48.00/semester	☐ $62.40/semester
$200,000	☐ $96.00/semester	☐ $124.80/semester
$300,000	☐ $144.00/semester	☐ $187.20/semester

Please attach a void cheque and sign Page 3.

SECTION II: COVERAGE PREFERENCES

What coverage do you request? Single Couple Family

For what Semester(s) would you like coverage:

FALL: October 1, 2019 to January 31, 2020 ☐

WINTER: February 1, 2020 to May 31, 2020 ☐

SUMMER: June 1, 2020 to September 30, 2020 ☐

PLEASE CONTINUE TO NEXT PAGE

SECTION III: COORDINATION OF BENEFITS

Please complete the section below if you already have Health and Dental coverage with another Plan but want to use this Benefit Plan as well and "coordinate your benefits" to increase your coverage. Should your other insurer be through your primary/full-time employer, this Plan will be your secondary payer and will reimburse any eligible unpaid remainder left from your first Plan. In the case that your other coverage is through your spouse's Plan, this Benefit Plan would be your first payer.

Other Coverage Information:	**Health:**		**Dental:**	
Do you have coverage with another insurer?	Yes	No	Yes	No
If yes, is this coverage from your other Employer? (Leave blank if not applicable).	Yes	No	Yes	No
Does your spouse have coverage with another insurer?	Yes	No	Yes	No
If yes, what level of coverage is provided?	Single	Family	Single	Family

Name of Insurance Company:		Policy/Group Number:	

SECTION IV: MONTHLY PREMIUMS

Single coverage - $36 (contract); $175 (no contract)

Couple coverage - $125 (contract); $475 (no contract)

Family coverage - $175 (contract); $500 (no contract)

All cheques should be made out to "CUPE LOCAL 4207" and mailed to Canadian Benefits

All Enrollment Forms must be accompanied by either:

- Cheque or post-dated cheques for the 1st of each semester

- Void Cheque for Premium Direct Withdrawal

- If you have previously submitted Banking Information for Direct Withdrawal, and want to use that information for this premium, please indicate here:

Please use banking information on file: YES_____ NO_____

All withdrawals will be made on the last Friday of the first month of the semester.

PLEASE SIGN THE NEXT PAGE

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SECTION V: DEPENDENT INFORMATION

Please complete the section below if you have selected Couple or Family Coverage.

Dependent Information					
	Last Name (if different than employee)	First Name	Date of Birth (YYYY / MM / DD)	Gender (M or F)	If child is over 21, indicate if disabled or if a full time student. If in school, provide name of school below and attach proof of enrolment. Terminates at age 25.
Spouse					
Child					
Child					
Child					
Child					

Plan Member/Employee Authorization

I hereby apply for group benefits coverage and authorize Canadian Benefits Consulting Group, the insurance company or their agents, or any other person or organization to release and exchange any and all information necessary for the purpose of determination of eligibility for benefits and administration of the group benefits plan. I confirm I am authorized to act on behalf of my spouse and/or dependants for such purposes.

I declare that the information provided is true, complete and accurate. Any copy of this authorization shall be valid as the original.

Member Signature _____ Date _____

To ensure that coverage is kept up to date for you and your dependents, it is vital that you advise your Plan Administrator of any changes such as change of name, marital status or dependents status, or reinstatement of benefits previously waived. Changes reported more than 30 days after the date of change may require evidence of insurability.

Canadian Benefits Consulting Group cannot accept any unsigned forms.

Canadian Benefits Consulting Group

Canadian Benefits Consulting Group is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.