

# PLAN MEMBER ENROLMENT FORM

- Complete this form on date of hire of a new plan member
- To submit, FAX or MAIL a photocopy of the completed form to Morneau Sobeco at:  
895 Don Mills Road, 4<sup>th</sup> Floor  
One Morneau Sobeco Centre  
Toronto ON M3C 1W3  
Fax: 1-877-464-0109
- Keep the original completed form in the plan member's personnel file

Morneau Sobeco Authorized Signature: \_\_\_\_\_

TO BE COMPLETED BY PLAN SPONSOR

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

Insurance company/Carrier name Carrier A)	Policy/group contract number: A)
Carrier B)	B)
Carrier C)	C)

## ① GROUP AND PLAN MEMBER INFORMATION

Group name and division number		Cost Centre (if applicable)		Occupation		Annual salary/earnings \$	
Employment status <input type="radio"/> Full-time <input type="radio"/> Part-time <input type="radio"/> Seasonal/Contract <input type="radio"/> Other:							
Plan member name (Last/First/Middle)				Sex <input type="radio"/> M <input type="radio"/> F		Family status <input type="radio"/> Single <input type="radio"/> Family	
Plan member mailing address				City		Province      Postal code	
Date of hire/re-hire(dd/mm/yyyy)	Plan member's class	Waiting period	Effective date (dd/mm/yyyy)	S.I.N (For Tax Reporting)	Plan member ID #		

## ② PLAN MEMBER 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		If you are a resident of British Columbia, please indicate Pharmacare Registration #	
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		Spouse's policy number			
Required health coverage <input type="radio"/> Single <input type="radio"/> Couple <input type="radio"/> Family <input type="radio"/> Waived*			Required dental coverage <input type="radio"/> Single <input type="radio"/> Couple <input type="radio"/> Family <input type="radio"/> Waived*		
Spouse/Child name (Last/First/Middle)		Birth date (dd/mm/yyyy)	Sex <input type="radio"/> M <input type="radio"/> F	Overage Full-time student? N/A	Disabled dependent? N/A
Spouse					
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/or dental coverage because you have comparable spousal coverage, you must complete a Waiver of Coverage Form. You can ONLY waive health and/or dental coverage.

## ③ BENEFICIARY DESIGNATION\*\*

Name of beneficiary for plan member's basic insurance (Last/First/Middle)	Percentage	Beneficiary revocable?*	Relationship to plan member
		<input type="radio"/> Yes <input type="radio"/> No	
		<input type="radio"/> Yes <input type="radio"/> No	
		<input type="radio"/> Yes <input type="radio"/> No	

In the event the Primary Beneficiary(ies) predeceases the plan member, the following Contingent Beneficiary(ies) shall be entitled to the benefits:

Name of contingent beneficiary for plan member's basic insurance (Last/First/Middle)	Percentage	Beneficiary revocable?*	Relationship to plan member
		<input type="radio"/> Yes <input type="radio"/> No	
		<input type="radio"/> Yes <input type="radio"/> No	
		<input type="radio"/> Yes <input type="radio"/> No	

\*\* In the province of Quebec, in the absence of an irrevocable/revocable designation, the legal spouse is deemed to be irrevocable and other beneficiaries are deemed to be revocable. An irrevocable designation cannot be changed without the beneficiary's written consent.

Name of trustee for beneficiaries under age 18 ***
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\*\*\* In Quebec, you should consult your legal advisor to create such a trust.

## ④ PLAN MEMBER DECLARATION

I consent to the collection, use, and exchange of my personal information by my plan sponsor, the administrators of my retirement, savings, and other group benefits programs, the agents retained by my plan sponsor or the administrator, an insurance company, and/or other person who requires information for the purpose of retirement, savings, or other group benefits plan administration. I authorize these parties to obtain, and exchange between them, any information about me, my spouse, or my dependent children that they require for the purposes of determining my benefit entitlements, and for record-keeping, file identification, reporting, underwriting, procurement of health information, claims adjudication and resolution, program management, and other services provided to me and my plan sponsor from time to time. I confirm that I have obtained the consent required of my spouse and any dependent children over the age of majority to permit me to give the above consent as it relates to their personal information. 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 plan sponsor's plan and authorize any required deductions.

I certify that the information given above is true and complete. A photocopy or electronic version of this authorization is as valid as the original.

\_\_\_\_\_  
Plan member signature

\_\_\_\_\_  
Date signed