



# GROUP ENROLLMENT FORM

# 1

**TO PROCESS YOUR ENROLLMENT, ALL APPLICABLE FIELDS ON THIS FORM MUST BE COMPLETED**

Select Package Level:  Signature  Supreme  Standard

Select Health Plan:  Essential  Essential Plus  Complete  Complete Plus

Select Dental Plan:  No Dental  Basic Dental  Enhanced Dental

I wish to be considered for the Optimum level of coverage & have included a Statement of Health form (Form 2)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Middle Initial: \_\_\_\_\_ Date Of Birth (MM/DD/YYYY): \_\_\_\_\_ Gender:  Female  Male

Street Address: \_\_\_\_\_

Apt: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Marital Status:  Single  Married  Separated  Divorced  Widowed  Common Law\*

### Enrollment Information For Dependants

Any dependants (including spouse) eligible for coverage must be listed below. Student refers to full-time post secondary enrollment of dependant children age 21-25.

Dependants:	First Name:	Last Name:	Gender: (M/F)	Date Of Birth: (MM/DD/YY)	Student: (Y/N)
Spouse:					
1 <sup>st</sup> Child:					
2 <sup>nd</sup> Child:					
3 <sup>rd</sup> Child:					
4 <sup>th</sup> Child:					

### For Employees Only (Current Position)

Part-Time  Casual  Contract  Temporary Date Hired (MM/DD/YYYY): \_\_\_\_\_

Occupation: \_\_\_\_\_ Gross Monthly Salary: \_\_\_\_\_ Average Weekly Hours: \_\_\_\_\_

Are you currently on maternity, disability or any other kind of leave?  Yes  No

Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_ Ext: \_\_\_\_\_

### For Retirees Only

Retired From Hospital Date Retired (MM/DD/YYYY): \_\_\_\_\_ Hospital: \_\_\_\_\_

Last Day Actively Worked At The Hospital (MM/DD/YYYY): \_\_\_\_\_

Did you retire while on a disability or any other kind of leave?  Yes  No

Are you currently collecting ANY long term disability benefits?  Yes  No



# GROUP ENROLLMENT FORM

# 1

**TO PROCESS YOUR ENROLLMENT, ALL APPLICABLE FIELDS ON THIS FORM MUST BE COMPLETED**

## Request For Pre-Authorized Payment Plan (Mandatory For All Enrollments)

I hereby authorize Health Care Providers to arrange automatic deductions from the following account:

Your Name As Shown On Your Account: \_\_\_\_\_

Name Of Financial Institution: \_\_\_\_\_

Street Address: \_\_\_\_\_

Unit: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Date (MM/DD/YYYY): \_\_\_\_\_ Signature: \_\_\_\_\_

I'm retired and would like my monthly premium withdrawn on the first of the month

Payment of your deposit and first month's premium: we require two cheques (NOT void) to be submitted with your enrollment and both must be made payable to HCP Group Insurance. Please ensure that the cheques provided are drawn from the account listed above. If paying via e-transfer or any other method, please attach a void cheque or pre-authorized debit form from your financial institution to your application. \*Your account must have chequing privileges\*

## Beneficiary Designation (For Signature & Supreme Package Enrollees Only)

Beneficiary: \_\_\_\_\_ Relationship To Insured: \_\_\_\_\_

Trustee (Must Name A Trustee If Beneficiary Is Under 18 Years of Age): \_\_\_\_\_

## Proof of Coverage (For Signature Package Enrollees Only)

Are you currently covered under your spouse's (or another group) benefits plan?  Yes  No

Provided By: \_\_\_\_\_ Insured Through: \_\_\_\_\_

## \*Declaration For Common-Law Coverage

I the undersigned, hereby certify that I have been living with \_\_\_\_\_ since (MM/DD/YYYY) \_\_\_\_\_ and representing him/her as my spouse or my (common-law) spouse. I further certify that I and/or my (common-law) spouse are solely responsible financially for either of our children claimed for insurance purposes. I further certify that I do not have or do not wish to provide coverage for my legal spouse, if any.

## Enrollment Acknowledgment

I hereby enroll for the benefit coverage from Health Care Providers Group Insurance Plan™ for which I am eligible, and I authorize the hospital to release my address, phone and income information to the plan administrator if required. I acknowledge all information is complete and accurate. I understand that I and my dependants must be covered under a provincial health plan and that I (retirees excluded) must be actively working in order to be eligible for coverage. I understand that the health evidence provided by me and my dependants as part of this enrollment may be used by all parties involved in the issuing of my coverage and I hereby consent to such usage on behalf of myself and any dependants for whom coverage is sought. I understand that Health Care Providers Group Insurance Plan™ reserves the right to audit claims. I understand that coverage is effective on the first of the month following the date that my enrollment is received, unless I elect to delay the effective date one month, provided all the requirements have been met:

- A fully completed, signed enrollment and required premium has been received
- Underwriting approval for instances where underwriting is required
- I continue to meet all eligibility rules

I acknowledge that it is my sole responsibility to inform Health Care Providers Group Insurance Plan™ of any changes in my work hours, status or otherwise in the event that it may affect my eligibility for coverage, and that failure to do so may result in premiums paid when coverage is not required and refunds under these circumstances will not be made.

Date (MM/DD/YYYY): \_\_\_\_\_ Signature of Employee: \_\_\_\_\_

PRIVACY: All information about the insurability of you and your dependants is considered confidential. Health Care Providers Group Insurance Plan™ is a business name registered to HMA The BENEFITS People and we are committed to protecting the privacy, confidentiality, accuracy and security of the personal information that is collected, used, retained and disclosed in the course of conducting business.