NEW PRIMARY ENROLLMENT FORM

7

OFFICE USE ONLY: **Open Window** (Y/N): _____ **Underwriting** (Y/N): _____

☐ I wish to convert my current coverage into a plan of my own

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:** _____

Current or Recently Ended Group Coverage Information

Please provide the following information regarding your current or recently ended group coverage with the Health Care Providers Group Insurance Plan:

Plan Holder's Name: _____ **Relationship To You:** _____

Plan Holder's Hospital Site: _____ **Last Day Covered** (MM/DD/YYYY): _____

Reason Existing or Prior Coverage Ended: _____

Please Indicate Your Current Marital Status

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

* 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.

Do you have dependents eligible for coverage under this plan? ☐ Yes ☐ No

If yes, please fill out chart below:

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:					
1st Child:					
2nd Child:					
3rd Child:					
4th Child:					

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Request For Pre-Authorized Payment Plan

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:** _____

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 instution to your application. ***Your account must have chequing privileges***

Enrollment Acknowledgment

I hereby enroll for the benefit coverage from Health Care Providers Group Insurance Plan™ for which I am eligible. 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

Date (MM/DD/YYYY)**:** _____ **Signature of Enrollee:** _____

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.