

Group Enrollment or Change Form

Complete this form to enroll for Employee Benefits or to change status of existing information. Refer to the back of this form for important instructions to accurately complete each section

A. NOTIFICATION:				<input type="checkbox"/> New enrollee	<input type="checkbox"/> Reinstatement of Employee	<input type="checkbox"/> Employee Termination
<input type="checkbox"/> Change dependent(s)				<input type="checkbox"/> Other Change: (please specify)		
Effective date: (mm/dd/yy)		Group No.:	Account No.:	P.I.D. No.:		

B. PERSONAL INFORMATION:				
Last name:	First name:	Initial:	Previous surname (if applicable):	
Home mailing address:	Street	City	Prov.	Postal Code
Date of Birth (mm/dd/yy)	____/____/____	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Common-law *

* **If common-law the following MUST be completed:** I have been living with and representing _____ as my spouse since _____ (mm/dd/yy). My common-law spouse and I are responsible financially for all our children claimed for insurance purposes. I further verify that I am not obliged to provide coverage for my legal spouse, if any.

Extended Health Care Coverage:				<input type="checkbox"/> Employee	<input type="checkbox"/> Employee/Spouse	<input type="checkbox"/> Employee/Child	<input type="checkbox"/> Family
Co-ordination of Benefits: Are you or your dependents eligible for Extended Health benefits from any other source or company? <input type="checkbox"/> Yes* <input type="checkbox"/> No							
* If yes, please complete Co-ordination of Benefits (GL1955) form.							
<input type="checkbox"/> Waiver: I am opting out as I and my dependents have Extended Health Care Benefits under my spouse's plan. I understand that if I wish to apply for Extended Health Care Benefits at a later date, I and/or any eligible dependents may be required to furnish at my own expense, evidence of insurability satisfactory to the insurance company.							
Dental Coverage:				<input type="checkbox"/> Employee	<input type="checkbox"/> Employee/Spouse	<input type="checkbox"/> Employee/Child	<input type="checkbox"/> Family
Co-ordination of Benefits: Are you or your dependents eligible for Dental benefits from any other source or company? <input type="checkbox"/> Yes* <input type="checkbox"/> No							
* If yes, please complete Co-ordination of Benefits (GL1955) form.							
<input type="checkbox"/> Waiver: I am opting out as I and my dependents have Dental Care Benefits under my spouse's plan. I understand that if I wish to apply for Dental Care Benefits at a later date I and/or any eligible dependents will be restricted to first year benefit limits as outlined in the group Policy.							

C. DEPENDENT ENROLLMENT:				Birthdate	Gender		
Add	Change	Delete	Dependent	Last Name	Initial	(mm/dd/yy)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spouse				<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1st Child				<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2nd Child				<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3rd Child				<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4th Child				<input type="checkbox"/> M <input type="checkbox"/> F

Please list additional dependents on separate sheet and attach. Overage dependents MUST complete Declaration of Student Eligibility form (GL1905).

D. BENEFICIARY DESIGNATION:			Relationship	% Share(must equal 100%)
Primary Beneficiary(ies)				
Contingent Beneficiary(ies) (Applicable if primary beneficiary(ies) predeceases employee)			Relationship	% Share(must equal 100%)

If a designated beneficiary is a minor, consider naming a Trustee: _____ Relationship to Employee: _____

E. EMPLOYEE SIGNATURE:	
Co-operators Life Insurance Company Privacy Statement	
Co-operators Life Insurance Company ("Co-operators") 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.	
I hereby apply for group benefits coverage and authorize the deduction from my pay and remittance to Co-operators any contributions required under the group benefits plan. I hereby authorize my employer, group plan administrator, Co-operators or their agents, or any other person or organization having any relevant information regarding me, my spouse or dependants to release and exchange any and all information necessary for the purposes 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 as valid as the original.	
Employee Signature: _____	Date: _____
Witness: _____ (Must be witnessed by someone other than a beneficiary.)	

F. EMPLOYMENT INFORMATION:	
Employer Name:	Employed at: <small>(designate main office, branch or subsidiary)</small>
Full-time employment commenced (mm/dd/yy):	Part-time employment commenced (mm/dd/yy):
Contract employment commenced (mm/dd/yy):	(Attach copy of contract) Minimum Weekly Hours Worked:
Occupation:	Class:
Present Salary:(\$)	<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-annually <input type="checkbox"/> Annually
<input type="checkbox"/> I confirm that this enrollee has been continuously in our employ since the date given and is at present working actively with pay.	
<input type="checkbox"/> I confirm that this enrollee has terminated employment.	
Signature:	Title:
Date:	Phone #: ()

G. OFFICE USE:

Status:
 Excess/Grandfathered Coverage:
 Status:
 Excess/Grandfathered Coverage:

Code:
 Amount:
 Code:
 Amount:

ENROLLMENT FORM INSTRUCTIONS

Please read these special notes carefully to complete the enrollment/change form.

Section "A" - NOTIFICATION (to be completed by the employer)

- 1) Check appropriate box in section "A" and indicate effective date. If an employee is rehired within the reinstatement period of the policy he/she will be considered a reinstated employee. If an employee is rehired after the reinstatement period of the policy he/she will be considered a new enrollee.
- 2) Indicate Group No., Account No. and PID No.

Section "B" - PERSONAL INFORMATION (to be completed by the employee)

- 1) Clearly print your name (last, first & initial) and full mailing address including postal code.
- 2) Enter date of birth in month, day, year format and mark an "x" to indicate gender and family status.
- 3) Complete the common law declaration with the name of your common law spouse and date of cohabitation.
- 4) For Extended Health Care and Dental check the appropriate coverage box. Indicate if coverage for you or your dependents is also available from another source (co-ordination of benefits). If you are eligible for coverage through your spouse's plan and choose to decline Extended Health Care and/or Dental coverage please check the appropriate box and complete the co-ordination of Benefits form.

Section "C" - DEPENDENT ENROLLMENT (to be completed by the employee)

- 1) Print last and first name of each person eligible to be covered under your employer's benefit policies. Attach separate sheet if additional space is required.
- 2) Enter the full birth date in month, day, year format for each dependent. Please ensure the accuracy of birth dates as it will affect claims payment and dependent eligibility
- 3) Indicate gender of dependent.

Section "D" - BENEFICIARY DESIGNATION (to be completed by the employee)

- 1) In the event the Primary Beneficiary(ies) predeceases the employee, the Contingent Beneficiary(ies) shall be entitled to the benefits. Where all beneficiaries predecease the employee, benefits shall be paid to the employee's estate.
- 2) If more than one beneficiary is listed under each category of beneficiary, benefits will be paid in equal shares unless other percentages provided. Percentages under each category must equal 100%.
- 3) Policy proceeds cannot be paid to a minor. If a minor is named as a beneficiary, you should name a trustee. If naming a trustee, you may want to consider creating a trust agreement or referencing an existing trust agreement.

Section "E" - EMPLOYEE SIGNATURE (to be completed by the employee)

Sign, date, and have signature witnessed. Signature must be witnessed by someone other than yourself or a beneficiary. Failure to have signature witnessed could result in a delay at time of claim.

Section "F" - EMPLOYMENT INFORMATION (to be completed by Employer)

- 1) Employer name (Please Print) and location type (designate main office, branch or subsidiary company).
- 2) Date full-time employment and/or date part-time employment and/or contract employment commenced. (Attach a copy of the employment contract.)
- 3) Indicate minimum weekly hours enrollee works and employee's occupation.
- 4) Record employee's present salary and check the appropriate rate of pay coincident with salary.
- 5) Select appropriate box for new enrollee or employee termination.
- 6) Sign and date .

**TO AVOID DELAYS, PLEASE ENSURE ALL REQUIRED INFORMATION IS PROVIDED
AND PROVIDE PROMPT NOTIFICATION OF CHANGES.**

Please keep a copy for your records.