GROUP COVERAGE ENROLMENT FORM

nexadmin

***All sections must be completed for processing**

Plan Sponsor

This section is to be completed by the plan administrator

The waiting period can only be waived with written consent from the insurer.

◯ New Enrolment ◯ Reinstatement of Coverage ◯ Change in Coverage Date: _____

Employer: _____ Division #: _____

Benefit Class: _____ Certificate#: _____ Province of employment: _____

Does the waiting period apply: ◯ Yes ◯ No Date of full-time employment/reinstatement: _____

Occupation: _____ Default Coverage Type: _____

Earnings: _____ Type: _____

Annually / Monthly / Weekly / Hourly

Schedule hours/week: _____

Employee Information

This section is to be completed by the employee

Please print clearly

Employee Lastname: _____ Employee First Name: _____

Gender: _____ Smoker: ◯ No ◯ Yes Date of Birth: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Do you have a spouse?: ◯ Yes ◯ No

Common Law spouse?: ◯ Yes ◯ No Date of co-habitation: _____

Do you have other dependents, which includes children/students/disabled persons? ◯ Yes ◯ No

Requested Coverage

This section is to be completed by the employee

Health, dental and/or vision coverage may only be removed if you have duplicate group benefits through your spouse's employer.

I understand the group benefits offered to me: ◯ I wish to apply for: ◯ I Decline to participate in:

Healthcare for	◯ myself	◯ myself and my dependents	◯ I refuse coverage
Dentalcare for	◯ myself	◯ myself and my dependents	◯ I refuse coverage
Visioncare for	◯ myself	◯ myself and my dependents	◯ I refuse coverage

Note: Coverage can only be refused if you and your dependents are covered by duplicate group benefits through your spouse's employer.

Spousal insurer's name: _____ Plan number: _____

If your spouse loses coverage you must apply for coverage within 31 days of loss of such coverage. If you do not apply within 31 days you and your dependents may be required to provide acceptable proof of your insurability to be covered. If you are approved, dental benefits, if applicable, may be limited. ***Please see your plan administrator for details.***

Family Information

This section is to be completed by the employee.
Complete this section only if you have requested dependent coverage above. Please print clearly.

Spouse/Common Law

Lastname: _____ First Name: _____

Date of Birth: _____ Gender: _____

What group benefits coverage does your spouse/ common law spouse have through their employer?

Dental	Health	Vision
◯ Single	◯ Single	◯ Single
◯ Family	◯ Family	◯ Family
◯ Waived	◯ Waived	◯ Waived
◯ None	◯ None	◯ None

Complete this section only if you have requested dependent coverage above. If there are more than 4 dependents, please attach a separate list. Please print clearly.

Dependant Information	Name(s)			Sex	Date of Birth	Full-time Student	Disabled
	First	Initial	Last	M/F	yyyy.mm.dd	☑	☑
Child						☐	☐
Child						☐	☐
Child						☐	☐
Child						☐	☐

For Over Age Student (students over age 21) please attach copy of student card. Until proof of student status is received, over age dependents will not be covered.

Beneficiary Designation

This section is to be completed by the employee

The original copy of this form will be required for a life claim.

If a beneficiary is not assigned "ESTATE" will be assumed.

Please print clearly

Beneficiary's Name(s)

Lastname	First Name	% Allocated	Relationship to Member

You must make your beneficiary designation revocable or irrevocable by checking one of the circles below. You may change a revocable beneficiary designation at any time. You may not change an irrevocable beneficiary designation or make certain changes to your plan without the written consent of their revocable beneficiary.

Note: Where Québec law applies and you have designated your married spouse or civil union spouse as beneficiary, the designation will be irrevocable unless you check the circle marked "Revocable" below.

I hereby make the above beneficiary designation: ◯ Revocable ◯ Irrevocable

If you are designating a trustee/administrator, we recommend you consult with a legal advisor, and with any proposed trustee/administrator.

The personal information willingly provided by me to my Plan Sponsor, the independent broker / sales advisor and / or The Insurer, collected on this Application and held in their files, will be used by The Insurer for the purposes of underwriting, servicing, administration, claims processing and adjudication related to this Application, the Group Insurance Policy and all benefits there under, and any supplementary documents. I understand and authorize that for the above purposes the personal information on file is accessible to, and may be exchanged with, authorized employees of, and relevant third parties retained by The Insurer, participating reinsurer(s), other insurance companies, investigative organizations, health care providers, including, but not limited to pharmacies, physicians and dentists and any other person or party whom I authorize.

If applying for my spouse and/ or dependents, I confirm that I am authorized to act on their behalf and therefore this consent and authorization also applies to the collection, use and communication of their personal information for the same purposes. I understand that all claims made under the Group Insurance Policy are submitted through me as insured Plan Member. I therefore authorize The Insurer to exchange information about these claims with me or any person acting on my behalf, including a spouse or dependent, as deemed necessary for the purposes of confirming eligibility and assessing and managing the claim.

Once completed, submit to:
NexAdmin®
c/o NexgenRx Inc.
145 The West Mall
P.O. Box 110 U
Toronto, Ontario M8Z 5M4

X _____ _____
Employee Signature Date