HealthSource Plus
Group Health Insurance - Benefit Administration

Group Enrolment

HSP Form No.1
05.0-E

Policy Number(s):

COMPLETE THIS FORM IN BLOCK LETTERS USING INK. FORMS WITH PENCIL WILL NOT BE ACCEPTED

A. Employer Information – To be completed by Employer

Employer's Name:

Employee Division N$^{o.}$:	Employee Unit N$^{o.}$:	Employee Certificate N$^{o.}$:

B. Employment Information - To be completed by Employer

Permanent full time hire date: Day:_____ Month: _____ Year: _____ ☐ New Hire ☐ Reinstatement/Rehire

Effective date of coverage: Day:_____ Month: _____ Year: _____ | Where a request has been made to waive the waiting period, please attach a letter detailing the reason.

Earnings: ☐ Hourly * ☐ Weekly ☐ Monthly ☐ Annually | *Regular hours worked per week:

Occupation:

C. Employee Information – (PLEASE PRINT IN BLOCK LETTERS)

		Sex	Birth Date D	M	Y
Last Name:					
First Name:		☐ M ☐ F			

Language Preference: ☐ English ☐ French

Mailing Address: _____
Street, Suite N$^{o.}$ City Province Postal Code

Work E-mail: | Home E-mail:

Do you have eligible dependent children? ☐ Yes ☐ No **Do you have a spouse / Common-Law Spouse?** ☐ Yes ☐ No
If yes, please complete the sections below

D. Spouse Information/Coordination of Benefit

		Sex	Birth Date D	M	Y
Last Name:					
First Name:		☐ M ☐ F			

Does your spouse have coverage with another insurer? ☐ Yes ☐ No
Name of spouse's Employer:

Name of spouse's Insurance Co.:
Policy or Group N$^{o.}$:

My spouse has: HEALTH: ☐ Family ☐ Single ☐ None

My spouse has: DENTAL: ☐ Family ☐ Single ☐ None

E. Waiver of Health and/or Dental Coverage

Important: Health and/or Dental benefits can only be waived if you and/or your dependents are covered by a spousal plan.
If spousal coverage is lost, you must apply for coverage within 31 days of loss, or proof of insurability will be required.

I wish to waive coverage for:
HEALTH CARE: ☐ Myself and my dependents ☐ My dependents only
DENTAL CARE: ☐ Myself and my dependents ☐ My dependents only

F. Dependent Children Information

Dependent's Last Name, First Name	Relation to Employee	Sex	Birth Date D	M	Y	If child is 22 or over indicate if disabled or student. **If student, attach proof of schooling.**
		☐ M ☐ F				Disabled: ☐ Yes ☐ No Student: ☐ Yes ☐ No
		☐ M ☐ F				Disabled: ☐ Yes ☐ No Student: ☐ Yes ☐ No
		☐ M ☐ F				Disabled: ☐ Yes ☐ No Student: ☐ Yes ☐ No
		☐ M ☐ F				Disabled: ☐ Yes ☐ No Student: ☐ Yes ☐ No

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G. Beneficiary Designation - If a Minor Beneficiary is appointed, you may wish to complete the Trustee Clause Section below

Last Name	First Name	Employee Relationship	%

For Quebec Residents, if Spouse is beneficiary, the designation is: ☐ **Revocable** ☐ **Irrevocable**

Important Note: The employee is the beneficiary of insurance on the lives of his or her dependents. Unless otherwise stipulated or prohibited by law, the designation is **Revocable**. If the beneficiary is shown as **Irrevocable**, his/her consent is required to change it. In Quebec the designation of your spouse as beneficiary is Irrevocable unless otherwise specified.

Minor Clause - Trustee for Children under the age of majority

Trustee Name: _____ Relationship to Life Insured: _____

As indicated above the Trustee is hereby appointed to receive any payment due on or after the life insured's death to any BENEFICIARY DESIGNATED in this form who is a minor on the date such payment(s) fall due.

Employee Authorization

I declare that the statements I have made on this form are true and complete. I understand that if any statement is incomplete or false and/or if I do not abide by the terms and conditions as set forth in the insurance policy and/or this application for insurance, my benefits may be terminated.
I certify that I am authorized to disclose and receive information about my spouse and/or my dependents.
I hereby authorize Health Source Plus Inc. as the administrator of my group health insurance plan to receive and maintain a record of the personal health information and claims history for myself and my dependents, and of my social insurance number (where applicable) on behalf of my employer and use such information to:

a) Verify eligibility & identify myself and/or my dependents;
b) Ensure my benefits are paid in accordance with the policy provisions;
c) Protect the plan from undue expenses due to error or fraud;
d) To allow my employer to audit, review and analyze claims trends as required.

I understand that spousal claims are only to be submitted where my spouse is not insured elsewhere or where a portion of the claim is not reimbursed under my spouses plan. I understand that dependent claims should first be submitted to the plan of the parent whose day and month of birth comes earlier in the year, and that only the portion not reimbursed may then be submitted to my plan.
I understand that Health Source Plus Inc. shall have the right to recover from myself and/or my dependents any payments made in error or as a result of fraud, as well as any costs related directly to the recovery of such funds.
I understand that if I waive benefits now and wish to reinstate my benefits in the future, I will be required to provide at my expense, satisfactory evidence of insurability and subject to the sole discretion of Health Source Plus Inc. my benefits may be reinstated.
I authorize my employer to deduct from my payroll any portion of the benefits program which I may be required to pay.

Name (Please Print) Signature Date Signed (dd/mm/yyyy)

Employer Authorization

I declare that the information provided on this form is complete and accurate to the best of my knowledge, and **I authorize** Health Source Plus to use this information to administer the group benefits plan; obtain quotes for underwritten/insured products within the plan; verify the identity and eligibility of the plan member, spouse or eligible dependents; adjudicate and pay eligible claims; audit plan expenditures; and, prepare reports.
I understand this information will only be provided to those insurers/adjudicators contracted by Health Source Plus to provide services within the plan.
I declare that I have obtained the Consent of this Employee (and the consent of the spouse or partner where applicable) to provide this information to Health Source Plus.

Name (Please Print) Signature Date Signed (dd/mm/yyyy)