HealthSource Plus ™
Group Benefits · Administration · Wellness · Retirement

Group Enrolment

HSP Form No.1
07.0-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°:	Employee Unit N°:	Employee Certificate N°:

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:		☐ M ☐ F			
First Name:					

Language Preference: ☐ English ☐ French

Mailing Address: ____
Street, Suite N°.   City   Province   Postal Code

Business Phone:	Home Phone:
Business 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:		☐ M ☐ F			
First Name:					

Does your spouse have access to **health coverage**? ☐ **Yes** - Check one: ☐Family ☐Single ☐Waived
☐ **No** - Check one: ☐Unemployed ☐Coverage not offered by employer

Does your spouse have access to **dental coverage**? ☐ **Yes** - Check one: ☐Family ☐Single ☐Waived
☐ **No** - Check one: ☐Unemployed ☐Coverage not offered by employer

Name of Spouse's Employer: ____

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 have spousal coverage and wish to waive this 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			If child is 21 or over indicate if disabled or student. **If student, attach proof of schooling.**
			D	M	Y	
		☐ 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.

H. 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 HealthSource 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 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;
e) Report any required information for tax purposes.

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 HealthSource 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 HealthSource 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)

I. Employer Authorization

I declare that the information provided on this form is complete and accurate to the best of my knowledge, and **I authorize** HealthSource 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 HealthSource 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 HealthSource Plus.

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