

Please return form to your District Benefits Administrator.
Administrators: This form is to be completed on the date of hire for new employees.

Group Enrolment Form

TTOC

Part 1: Employee and Basic Insurance Information

Employee's Last Name		First Name	Initial	ID Number ¹			
Street Address		E-mail Address		Birthdate (MM/DD/YY)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Family Status <input type="checkbox"/> Single <input type="checkbox"/> Couple <input type="checkbox"/> Family	
City		Province	Postal Code				
Dependents						Provide name of school and student number below if child is over 21 and studying full time. If child is disabled, state nature of disability and attach full details. If adding an adopted child, provide date of adoption. If adding a legal ward, provide court document.	
First Name	Initial	Last Name (if different from Employee)	Birthdate (MM/DD/YY)	Relationship	Gender (M/F)		Required coverage
							<input type="checkbox"/> Dental
							<input type="checkbox"/> Dental
							<input type="checkbox"/> Dental

Part 2: Spousal or Other Coverage

Are you or your dependents covered for dental benefits by another plan? <input type="checkbox"/> No <input type="checkbox"/> Yes (specify)	Benefit Dental	Name of Carrier/Policy #	Effective Date	ID Number	Coverage <input type="checkbox"/> Single <input type="checkbox"/> Couple <input type="checkbox"/> Family
	Employment type: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Retiree				

Part 3: Personal Data Consent

I consent to the collection, use, and disclosure of my personal information by my Plan Sponsor/Employer or the administrator, an insurance company, or any other person or organization having any relevant information about me (collectively "the Parties") who require this information for the purpose of administering my group benefits under the plan. I authorize the Parties to obtain and exchange between them, any personal information about me, my spouse, and my dependent children for the purpose of determining benefit entitlements, and for record keeping, file identification, reporting, underwriting, procurement of health information, claims adjudication and resolution, program management, administration of the plan and other services provided from time to time.

I confirm that I have obtained consent from my spouse and any dependent children over the age of majority, to disclose their personal information to the Parties as required for the administration of the plan.

In the case of death, I expressly authorize my employer, the policyholder, the beneficiary, heir or liquidator of my estate to provide the Insurance companies, when required by the latter, with all the information and authorizations required for the processing of any claim(s).

I hereby apply for group benefits under my Plan Sponsor's/Employer's plan and authorize any required deductions. I certify that the information given above is true and complete. A photocopy of this authorization is as valid as the original. The original enrolment form will be retained by my Plan Sponsor/Employer.

Employee Signature _____

Date Signed (MM/DD/YY) _

Part 4: For Plan Administrator/Employer Use Only

Name of Employer / Organization		Employment Type <input type="checkbox"/> Full-time Permanent <input type="checkbox"/> Part-time Permanent <input type="checkbox"/> Temporary <input type="checkbox"/> Retiree			Division	Class
Employee's Occupation/Position		Annual Earnings \$	Date of Hire (MM/DD/YY)	Hours Worked Per Week		
Dental Waiting Period	Effective (MM/DD/YY)					

¹ Please provide Employee ID/Payroll number. Please, do not use Social Insurance Number (SIN) as an employee ID.