claimsecure
when precision matters

Enrolment Form

www.claimsecure.com

Plan Sponsor Information

Employer/Company Name			
Group No.	Division No.	Unit No.	Certificate No.
Action Code			Effective Date of Action (dd/mm/yy)
Add ☐	Change ☐	Delete ☐	

Plan Member Information

Surname		First Name		
Address		City or Town	Province	Postal Code
Date of Birth (dd/mm/yy)	Date of Hire (dd/mm/yy)	Gender		Language
		Male ☐	Female ☐	English ☐ French ☐

Dependant Information

Surname	First Name	Date of Birth (dd/mm/yy)	Relationship to Member	Effective Date (dd/mm/yy)	Action Code Add/Change/Delete	Gender
						Female ☐ Male ☐
						Female ☐ Male ☐
						Female ☐ Male ☐
						Female ☐ Male ☐
						Female ☐ Male ☐
						Female ☐ Male ☐
						Female ☐ Male ☐

Note: Relationship to member: Spouse, Child, Disable or OverAge Dependent (If OverAge Dependent complete below)

OverAge Dependent Information (OAD)

Surname	First Name	Date of Birth (dd/mm/yy)	School Start Date	School End Date	School Name (Optional)
				August 31/ ____	
				August 31/ ____	

Note: Coverage for OAD terminates on August 31st of each year therefore, the member must re-apply if the child re-enrolls the next school year

Benefit Coverage Information

Member Coverage Status						**Spousal Coordination of Benefit Status**					
Health			Dental			Health			Dental		
Family ☐	Single ☐	Waive ☐	Family ☐	Single ☐	Waive ☐	Family ☐	Single ☐	Waive ☐	Family ☐	Single ☐	Waive ☐

For **Quebec** residents age 65 or over, select the senior ID code:

Member: RAMQ ☐ Both ☐ Private ☐ / **Spouse:** RAMQ ☐ Both ☐ Private ☐

AUTHORIZATION

I hereby authorize ClaimSecure to use my Social Insurance Number, where required, to administer my health and dental benefit plan. I also authorize ClaimSecure, healthcare providers, insurers, administrators of government or other benefit plans and other service providers working with ClaimSecure to exchange necessary information to administer my health and dental benefit plan. I confirm that I am authorized to act on behalf of myself, my spouse and dependents when applying for coverage, or for purposes of the ongoing administration of my health and dental benefit plan.

Plan Member Authorization

Signature of Plan Member	Print Name	Date signed (dd/mm/yy)

Plan Sponsor Authorization

Signature of Plan Administrator	Print Name	Date signed (dd/mm/yy)

Please complete form and send to:

E-mail: eligibilityupdates@claimsecure.com

Fax: 1-705-673-5968

Or mail: CLAIMSECURE INC. PO BOX 6500 STN A SUDBURY ON P3A 5N5

Phone: 1-888-513-4464