claimsecure
when precision matters

# Enrolment Form

www.claimsecure.com

## Plan Sponsor Information

| Employer/Company Name | | | |
|---|---|---|---|
| | | | |
| Group No. | Division No. | Class 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) | Sex Assigned at Birth | | 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