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when precision matters

Enrolment Form (Third-Party Administration)

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Plan Sponsor Information

Employer/Company Name					
Group No.	Division No.	Unit No.	Certificate No.	Effective Date of Action (dd/mm/yy)	
Action Code			Date of Full-Time Employment (dd/mm/yy)	Date of Full-Time Employment (dd/mm/yy)	Re-Hire Date (dd/mm/yy)
Add ☐	Change ☐	Delete ☐			
Occupation					Regular Hours / Week
Salary Information					
Earnings:	Annually ☐	Monthly ☐	Bi-Weekly ☐	Weekly ☐	Hourly ☐

Plan Member Information

Surname	First Name	Middle Initial	
Address	City or Town	Province	Postal Code
Date of Birth (dd/mm/yy)	Smoker Status	Gender	Language
	Yes ☐ No ☐	Male ☐ Female ☐	English ☐ French ☐

Dependant Information

Spouse 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 ☐

Note: For common-law or same sex spousal status, the couple must have been cohabitating as defined by the policy(ies) guideline for dependent eligibility. If common-law or same sex spouse, please provide date the co-habitation commenced (dd/mm/yy):

Children 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 ☐

Relationship to member: Child, Disabled 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 ☐

Spousal Exemption

If you or your dependents are presently covered for Extended Health Care and/or Dental Care benefits under another group contract, you may refuse coverage for such benefit(s) under this contract by selecting the applicable box for each benefit. If you lose spousal coverage, you must apply for coverage within 31 days of the loss of such coverage.

I refuse coverage for myself and my dependents under:	Extended Health ☐	Dental ☐
I refuse coverage for my dependents under:	Extended Health ☐	Dental ☐

Name of Spouse's Benefit Carrier	Effective Date of Spouse's Benefit Coverage (dd/mm/yy)

Beneficiary Designation (for Life and/or AD&D Benefits)

The original of this form will be required for a life claim. If a beneficiary is not assigned, "Estate" will be assumed. Crossed out or corrected beneficiary designations must be initialed. Correction fluid cannot be used. Please print clearly, in Ink.

Beneficiary(ies)

Surname	First Name	Middle Initial	Percentage Allocated	Relationship to Plan Member

For Quebec Residents Only: In Quebec, the designation of your spouse as beneficiary is Irrevocable unless you check the box marked "Revocable" below. If designation is irrevocable, the consent of the Beneficiary is required to change this designation.

I hereby make the above beneficiary designation of my spouse:

☐ **Revocable, I may change this beneficiary designation at any time without the consent of the Beneficiary.**

Minor Clause – Trustee Designation for children under the age of majority:

Name of Trustee	Relationship to Member Insured

If designating a beneficiary who is under the age of majority or who lacks legal capacity you may wish to appoint a trustee/administrator. This appointment may not be suitable for all purposes. If you are designating a trustee/administrator, we recommend you consult with a legal adviser, and with any proposed trustee/administrator.

Authorizations and Declarations:

- **I designate the person(s) named above under Beneficiary Designation as my beneficiary.**
- **I confirm that I am authorized to release information concerning my spouse and my dependents for the purpose of determining their eligibility for benefits.**
- **If my Social Insurance Number is used as my certificate number, I authorize its use for the identification and administration of my group benefits.**
- **I authorize ClaimSecure, healthcare providers, insurers, administrators of government or other benefit plans, and other service providers working with ClaimSecure, to exchange necessary information to determine my eligibility for coverage and to administer my benefits 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 benefits plan.**
- **I agree that a photocopy or electronic copy of this Authorizations and Declarations section is as valid as the original.**
- **I certify that the information contained in this form is true and complete, to the best of my knowledge.**

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