CANADIAN BENEFIT PROVIDERS

# PLAN MEMBER ENROLMENT FORM

## PLAN SPONSOR SECTION (to be completed by the Plan Administrator)

| | | | | | |
|---|---|---|---|---|---|
| PLAN SPONSOR/GROUP NAME | | | | | |
| GROUP NO. | | DIVISION NO. | | | |
| BENEFIT CLASS | | ID # | | | |
| DATE OF FULL-TIME EMPLOYMENT (mm/dd/yyyy) | | DATE ELIGIBLE (mm/dd/yyyy) | | | |
| OCCUPATION | | | | | |
| ANNUAL EARNINGS | | NO. OF HOURS PER WEEK | | WAIVE WAIT PERIOD (Y/N) | |
| PLAN MEMBER'S RESIDENCE PROVINCE | | PLAN MEMBER'S PROVINCE OF EMPLOYMENT | | | |
| PLAN ADMINISTRATOR'S SIGNATURE | | | | | |

## PLAN MEMBER SECTION (to be completed by the Plan Member)

Must be a permanent Canadian resident with valid Provincial Health coverage

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| LAST NAME | | FIRST NAME | | | MIDDLE INITIAL | | |
| DATE OF BIRTH (mm/dd/yyyy) | | GENDER: (M/F) | | MARITAL STATUS | | | |
| MAILING ADDRESS | | | CITY | | PROVINCE | POSTAL CODE | |
| | | | | | | | |
| PHONE NUMBER | | EMAIL (REQUIRED FOR ONLINE SERVICES & DIRECT CLAIM PAYMENT) | | | | | |
| | | | | | | | |

## APPLICATION FOR COVERAGE

If provided by the policy, I elect the following coverage:

| | Single | Family | Waived |
|---|---|---|---|
| Health | ☐ | ☐ | ☐ |
| Dental | ☐ | ☐ | ☐ |

Health and/or Dental coverage may only be removed if you have DUPLICATE group benefits through your spouse's employer. If you lose spousal coverage you must apply for coverage within 31 days of loss of such coverage. If you do not apply within 31 days you may be required to provide acceptable proof of your insurability to be covered. If you are approved, dental benefits, if applicable, may be restricted. Please see your plan administrator for details.

## COORDINATION OF BENEFITS

| | |
|---|---|
| SPOUSAL INSURANCE COMPANY NAME | |
| POLICY NO. | |
| EFFECTIVE DATE OF PLAN (IF KNOWN) | |

What Group Benefits coverage does your spouse/common-law spouse have through an employer?

| | Single | Family |
|---|---|---|
| Health | ☐ | ☐ |
| Dental | ☐ | ☐ |

## DEPENDANT INFORMATION

| LAST NAME | FIRST NAME | RELATIONSHIP (SPOUSE/CHILD) | DATE OF BIRTH (mm/dd/yyyy) | GENDER (M/F) | FULL-TIME STUDENT (Y/N) * | DISABLED DEPENDANT (Y/N)** |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

**All dependents must be permanent residents of Canada with valid Provincial Health Care coverage.**

*Proof of post-secondary school enrolment may be requested and will be required, if children are older than 21 years of age.

**Please complete disabled dependant application form.

## BANKING INFORMATION For Direct Claim Payment

Please provide bank account details in the boxes below.

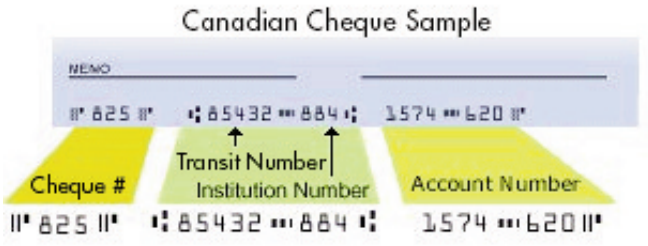
**BANKING INFORMATION:**

Name of Financial Institution: _____

Transit Number (5 digits): _____

Institution Number (3 digits): _____

Account Number: _____




## PERSONAL INFORMATION RELEASE

Please list any individuals that you would like to have access to your personal information under your Group Benefit Plan. Personal information includes, but is not limited to: ID number, dependant information, beneficiary information and claim information.

| NAME OF INDIVIDUAL | RELATIONSHIP TO YOU |
|---|---|
| | |
| | |
| | |

We will continue to allow the individuals listed above access to your personal information until such time as you advise us not to.

NOTE: An insured person is eligible for this coverage only if the following applies: if you live & work in Canada as a permanent employee for this Employer, have provincial health care coverage in your province of residence, and meet any additional criteria as defined by the group contract.

## AUTHORIZATION & DECLARATIONS

*Whereas the "Company" refers to Canadian Benefit Providers Inc., **I certify** that the information in this form is true and complete to the best of my knowledge. **I acknowledge** and agree that this Coverage or any portion of this Coverage, and future claims thereunder may be denied or terminated as a result of the provision of false, incomplete, or misleading information. **I authorize** the collection, use, maintenance and disclosure of personal information relevant to this application ("Information") for the purposes of Group Benefits plan administration, audit, assessment, investigation, claim management, underwriting and for determining plan eligibility ("Purposes"). **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with my Plan Advisor, its re-insurers and/or its service providers, for the Purposes. **I understand** that any Information provided to or collected in accordance with this authorization, will be kept in a Group Benefits life, health or disability file. Access to my Information will be limited to: Plan Advisor employees, representatives, re insurers, and service providers in the performance of their jobs; Persons to whom I have granted access; and Persons authorized by law. **I authorize** all future claims payments to be sent via electronic funds transfer to the bank account listed here. **I agree** that I will access my Explanation of Benefits via the secured employee web portal and that I will maintain a current email address to receive notification of payments as they occur. **I recognize** that it is my responsibility to ensure that my file is kept up-to-date with my preferred bank account information and personal information. **I agree** that the Company will not be responsible for any payments that are lost or misdirected due to incorrect banking information. **I authorize** the deduction from my pay of any contributions I must make towards the cost of these benefits. **I agree** that a photocopy or electronic version of this authorization is valid.*

| PLAN MEMBER'S SIGNATURE | DATE (mm/dd/yyyy) |
|---|---|
| | |

**Forward completed form to**: admin@cbproviders.ca
Canadian Benefits Providers Inc. 301-8925 51 AVE NW EDMONTON AB T6E 5J3 Canada P | 780.944.9166, F | 780.944.9168, TOLL FREE: P | 1.855.944.9166, F | 1.844.944.9168, www.cbproviders.ca

CANADIAN BENEFIT PROVIDERS

# BENEFICIARY FORM

## PART 1 | YOUR INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| PLAN SPONSOR/GROUP NAME | | | | | |
| PLAN MEMBER NAME (Last Name, First Name) | | | | DATE OF BIRTH (mm/dd/yyyy) | |
| GROUP # | | | | MEMBER ID # | |
| MAILING ADDRESS | | | | | |
| CITY | | PROVINCE | | POSTAL CODE | |
| PRIMARY PHONE | | EMAIL | | | |

## PART 2 | BENEFICIARY DESIGNATION

*This section is to be completed by the Plan Member to designate a beneficiary for your life benefits. The original copy of this form will be required for a life claim. If you do not designate a beneficiary, for benefits payable upon death, the beneficiary will be the ESTATE.* ***Do not scratch-out or white-out any information in this section.***

### Beneficiary's Names

| FIRST NAME | LAST NAME | MIDDLE INITIAL | DATE OF BIRTH (mm/dd/yyyy) | PERCENT ALLOCATED * | RELATIONSHIP TO PLAN MEMBER |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**** The above percentages must total 100% to be valid***

### Contingent Beneficiary (If all my beneficiaries pre-decease me, I designate the following as my beneficiary).

| FIRST NAME | LAST NAME | MIDDLE INITIAL | DATE OF BIRTH (mm/dd/yyyy) | PERCENT ALLOCATED * | RELATIONSHIP TO PLAN MEMBER |
|---|---|---|---|---|---|
| | | | | | |

Where Québec law applies and you have designated your married spouse or civil union spouse as beneficiary, the designation will be irrevocable. In all other provinces: the beneficiary is revocable.

## PART 3 | TRUSTEE DESIGNATION (not available in Quebec):

*Trustee Name (required for Beneficiaries Under 18):* _____

*Relationship to member* _____

*If you are designating a trustee/administrator, we recommend you consult with a legal advisor, and with any proposed trustee/administrator.*

## PART 4 | AUTHORIZATION AND DECLARATIONS

Whereas the "Company" refers to Canadian Benefits Providers Inc., I certify that the information in this form is true and complete to the best of my knowledge. I acknowledge and agree that this Coverage or any portion of this Coverage, and future claims thereunder may be denied or terminated as a result of the provision of false, incomplete, or misleading information. I authorize the collection, use, maintenance and disclosure of personal information relevant to this application ("Information") for the purposes of Group Benefits plan administration, audit, assessment, investigation, claim management, underwriting and for determining plan eligibility ("Purposes").

I authorize any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with my Plan Advisor, its reinsurers and/or its service providers, for the Purposes. I understand that any Information provided to or collected in accordance with this authorization, will be kept in a Group Benefits life, health or disability file. Access to my Information will be limited to: Plan Advisor employees, representatives, reinsurers, and service providers in the performance of their jobs; Persons to whom I have granted access; and Persons authorized by law. I designate the person(s) named under the Beneficiary Designation as my beneficiary. The person(s) designated on this form will replace all previous designations for my beneficiary. I agree that a photocopy or electronic version of this authorization is valid.

| PLAN MEMBER'S SIGNATURE | DATE SIGNED (mm/dd/yyyy) |
|---|---|
| | |

**Send completed and original forms to your Plan Administrator; retain a copy for your files.**

**Questions?**
Call us at 780.944.9166 ext 280, or toll free at 855.944.9166 ext 280
Mail | Canadian Benefit Providers, 301-8925 51 AVE NW Edmonton AB T6E 5J3 Canada

**Plan administrators, forward this completed form by email, fax or mail to:**
Email | admin@cbproviders.ca Fax | 1.844.944.9168
Mail | Canadian Benefit Providers, 301-8925 51 AVE NW Edmonton AB T6E 5J3 Canada