# Advanced Benefit Solutions Inc.

**PO Box 1860, Didsbury, AB T0M 0W0**

❑ **New Enrolment** ❑ **Changes to Existing Enrolment**

Today' Date: ________________ ❑ New Hire / ❑ Re-Hire Effective Date: _______________

**Employer / Plan Section (to be completed by the plan administrator)**

Company Name:_______________________________________Policy No:__________________

Date of Permanent Full-time:______________________________Effective Date:______________

Occupation:____________________________________Earnings: _________________________

Class / Division:___________________________

**Employee / Participant Details (to be completed by the employee)**

Last Name:_________________ First Name:________________Middle Initial:___ M/F:_________

Address:_____________________________________________________________________

City:______________________________Province:___________________Postal Code:__________

Phone Number (Home): ___________________________(Work): __________________________

Email Address:______________________________Date of Birth: (mm/dd/yyyy):______________

Marital Status: ______________________________Select Coverage Status: ❑ Single ❑ Family

**Dependent Details (to be completed by the employee)**

Spouse: Last Name:_________________First:________________Sex:___DOB:_______________

Child 1: Last Name:_________________First:________________Sex:___DOB:_______________

Child 2: Last Name:_________________First:________________Sex:___DOB:_______________

Child 3: Last Name:_________________First:________________Sex:___DOB:_______________

Child 4: Last Name:__________________First:________________Sex:___DOB:_______________

**Please indicate below if any of your dependents are full time students over age 21**

| Name of Over Age Student | College/University Attended | Enrolled From | Enrolled To |
|---|---|---|---|
| ________________________ | _________________________ | ____________ | _____________ |
| ________________________ | _________________________ | ____________ | _____________ |

Please indicate the name of any disabled dependents:___________________________________

## Co-ordination of Benefits / Refusal of Coverage (to be completed by the employee)

If you and/or your dependents are presently insured for Health Care and/or Dental benefits under your spouse's group policy you may co-ordinate benefits or refuse coverage under this contract by completing the appropriate areas.

My spouse has coverage through ________________________(Name of insurance company)
Policy number for spouse's plan______________________________

- ❑ I wish to co-ordinate coverage with my spouse's plan
- ❑ I refuse insurance on myself and dependents under: Health_____ Dental_____
- ❑ I refuse insurance on my dependents under: Health_____ Dental_____

## Revocable Beneficiary Nomination (to be completed by the employee)

| Beneficiary's Full Name | DOB | Relationship | Percentage Allocated |
|---|---|---|---|
| ______________________ | ____________ | ____________ | _____% |
| ______________________ | ____________ | ____________ | _____% |
| ______________________ | ____________ | ____________ | _____% |

Trustee's Full Name (See Below): ______________________________________

**Please note that benefits cannot be paid to beneficiaries who are minors.**
**A trustee must be appointed (not applicable in Quebec).**

Where Quebec law is applicable, a spouse beneficiary is irrevocable unless you make the designation revocable.
❑ I hereby make the designation Revocable

## Stop Loss if applicable (to be completed by the employee)

As part of the Health benefit provided through my employer (myself and my dependents) wish to be insured under the group insurance stop loss protection program.

Note: For consideration under this policy the following questions must be completed

1. Have you or any of your dependents, on an individual basis, incurred more than $1,750.00 in health expenses in the last twelve (12) month period? ❑Yes ❑No
2. If yes, the approximate amount incurred $________________
3. Name of applicable person (dependent):__________________________DOB:______________

I hereby authorize the release of medical claims information solely for the purposes of determining eligibility and validating claims under this policy. I understand that this information can be forwarded to any other third party and will only be used for determining eligibility and validating the claim according to the terms of the Group Insurance Stop Loss Policy.

## Authorization (to be completed by the employee)

By enrolling in this plan I am authorizing the applicable insurance carriers, agents and service providers to use and exchange information collected in this form to underwrite, administer and adjudicate claims. I also authorize my plan sponsor to use this same information for benefits administration and to make any necessary payroll deductions, which may be required.

Employee / Participant Signature:________________________________

Employee / Participant Name (Please Print):__________________________

Date:______________________