ONTARIO UFCW ELHT
EMPLOYEE LIFE & HEALTH TRUST FUND

REQUEST FOR ENROLMENT
Group Insurance Plan

☐ New enrolment
☐ Modification

As the employer, please complete Section 1 and hand the form to the employee to complete the other sections. Once completed, please submit the original form to the plan administrator, Prudent Benefits Administration Services Inc. (PBAS), and keep a copy for your record.

Email: ontufcwclaims@pbas.ca **Toll Free:** (800) 461-4361 **Fax**: (416) 674-1525 **Mail**: Ontario UFCW ELHT Employee Life & Health Trust Fund 110 - 61 International Blvd. Toronto, ON M9W 6K4

1. EMPLOYER SECTION (Complete in ink print clearly)

Policyholder's name (employer/organization) **Ontario UFCW ELHT Employee Life & Health Trust Fund** Plan ID **OUFCW**

Location name and no. (store, branch or other) _____ Insurer name **The PBAS Group**

Employment status (regular or part-time) _____ Occupation (Plan member profession or position) _____

Province of employment _____ Province of residence _____

Hire date or rehire (YYYY/MM/DD) _____ Hours worked per week _____

SIN Number _____ Telephone _____

2. PLAN MEMBER INFORMATION (Complete in ink print clearly)

Plan member first name _____ Last name _____

Address _____ Postal code _____
Indicate complete address including civic number, street, apartment, city, province

E-mail _____ **Requested Coverage**: ☐ Individual ☐ Family

Date of birth _____ (YYYY/MM/DD) Language of communication ☐ French ☐ English

Do you have a spouse? Married, common-law or civil union spouse ☐ Yes ☐ No Date of cohabitation, if common-law: _____ (YYYY/MM/DD)

Do you have dependent children? Including full-time students or disabled children ☐ Yes ☐ No Number _____ of children

3. SPOUSE INFORMATION (Complete in ink print clearly)

Spouse first name _____ Last name _____

Date of birth (YYYY/MM/DD) _____

Does your spouse have health care coverage under another group plan? ☐ Yes ☐ No If Yes, indicate coverage ☐ Individual ☐ Family

Effective date (YYYY/MM/DD) : _____

Name of spouse's insurer _____

Policy no. _____

Note: If you lose coverage under your spouse's plan, you must submit a request for coverage under this plan within 31 days of loss of coverage. If you do not apply for coverage within this time, you and your dependants will need to provide proof of insurability and be approved by the insurer before coverage can take effect. Certain coverage restrictions may apply.

4. DEPENDENT CHILDREN INFORMATION (Complete in ink print clearly)

First name	Last name	Date of birth (YYYY/MM/DD)	Full-time Student	Disabled Child
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

Note: The age limit to cover dependent children varies with each plan. Please consult your plan booklet or contact the plan administrator for details.

Plan member first name _____ Last name _____

5. DESIGNATION OF BENEFICIARIES (Complete in ink print clearly)

Please complete this section to designate a beneficiary for your life insurance. The payable benefit will be divided according to the allocation percentages listed as indicated or in equal parts if no percentages are indicated. If you name more than one beneficiary, the total of percentages must be equal to or less than 100% (if less than 100%, the difference is paid to the estate). If you do not designate a beneficiary, the insurance benefit will be paid to your estate. Please initial next to a crossed-out designation. You may change this designation at any time by completing a new form. A copy of this form will be accepted when making a claim.

I hereby revoke all previous beneficiary designations and designate the following persons as beneficiaries.

First name	**Last name**	**Relationship to plan member**	**Date of birth** (YYYY/MM/DD)	**Allocation %** (Total 100%)

CONTINGENT BENEFICIARIES This section is optional. If you wish, you may appoint contingent beneficiaries below in the event that all primary beneficiaries (above) predecease you. If there are no surviving beneficiaries at the time of your death, the insurance benefit will be paid to your estate.

First name	**Last name**	**Relationship to plan member**	**Date of birth** (YYYY/MM/DD)	**Allocation %** (Total 100%)

Note: A revocable designation allows you to change this designation in the future. Otherwise, to change the designation of an irrevocable beneficiary, the written consent of the latter will be required.

The payment of a benefit to a beneficiary who is a minor or who lacks the necessary legal capacity at the time of payment, shall be made to his or her legal guardian(s) or curator(s), unless a valid trust has been established for the benefit of the beneficiary, by will or by separate contract, to receive the payment and the administrator or insurer has been provided notice of this trust. If a valid trust exists, please designate the trust as the beneficiary in the section above. Before designating a trust, it is recommended that you consult a legal advisor.

7. DIRECT DEPOSIT ENROLMENT (Complete in ink print clearly)

Please complete this section to enroll in direct deposit or to change your information. Direct deposit is a convenient, fast and reliable way to have your claims reimbursed directly to your bank account. **A valid email address is required to enroll in direct deposit**. When a reimbursement is issued, you will receive an explanation of benefits by email and the refund will be sent to your bank account.

PLAN MEMBER INFORMATION

Email _____ (Mandatory)

Telephone _____ at home

Mobile _____ Telephone

BANKING INFORMATION

Please attach a cheque sample, a copy of a cheque or provide a direct deposit form from your financial institution with your banking information.

Account holder first name _____ Last name _____

Name of financial institution (must be in Canada) _____

Address of institution _____ Indicate the full address

Plan member first name _____ Last name _____

8. DISCLOSURE NOTICE, PRIVACY AND CONFIDENTIALITY (Complete in ink print clearly)

The insurer and plan administrator recognize and respect the importance of privacy. The information collected regarding you and your dependants is kept confidential and is only used for the purposes for which it was provided.

Your file is kept in the offices of the plan administrator. You have certain rights of access and rectification with respect to your information, and you may exercise this right by submitting a written request to the insurer or plan administrator.

We limit access to your file to authorized staff or persons who require it to perform their duties, as well as to persons to whom you have granted a right of access and those authorized under provincial and federal laws.

Personal information is collected and some is shared with the employer or policyholder, your insurer, its reinsurers, representatives, financial auditors and service providers, such as your pharmacy, electronic payment card manager and health care providers, for the purposes of plan administration, underwriting, pricing, and benefit analysis and processing for you and your dependants.

A detailed Privacy Policy can be found online at https://www.pbas.ca/about/privacy or by contacting the plan administrator's office.

9. PLAN MEMBER AUTHORIZATION AND DECLARATION (Complete in ink print clearly)

I hereby apply for the benefits for which I am eligible under the group insurance plan established by the insurer and offered by my employer or the policyholder, subject to any opt-out mentioned above.

I confirm that I am authorized to disclose personal information regarding my dependants for the purpose of determining their eligibility for benefits, to the extent the benefits concern them. I confirm that I am authorized to act on their behalf.

I authorize the use of my Social Insurance Number when necessary in the administration of the plan, for any income tax return to be issued by the administrator or insurer, and if applicable, as an identification number.

I authorize my employer or the policyholder to deduct the required plan member contributions from my pay and remit them to the plan administrator.

I have read and understand the section entitled "Disclosure Notice, Privacy and Confidentiality" of this form and agree to its contents. I consent, on my own behalf and on behalf of my dependants, to the collection, use and sharing of the information provided in this form as described in the "Disclosure Notice, Privacy and Confidentiality" section of this form.

If I enrolled for direct deposit for the reimbursement of my claims and those of my dependants (Section 8):

I hereby authorize the insurer, the plan administrator, their administrators and service providers, to deposit the amounts into my bank account as set out in section 8 above.

I also understand that I am personally responsible for the confidentiality and security of personal information transmitted by email or by any other means, as well as for the accuracy and any updates to my banking information. If, as a result of an error or omission on my part, amounts are deposited in an incorrect bank account, I will be held responsible and I will have to reimburse the insurer or the plan administrator if the amounts cannot be recovered.

My direct deposit enrolment may be terminated at any time by submitting a written notice to the plan administrator. If my eligibility to the plan coverage terminates, this direct deposit authorization will be automatically cancelled. In addition, the insurer or the plan administrator reserves the right to terminate the direct deposit service without notice.

I acknowledge that a copy of this authorization and declaration has the same validity as the original.

I certify that the information provided in this form is true, accurate and complete.

Date of signature _____ Plan Member Signature _____
(YYYY/MM/DD)