GROUP INSURANCE PLAN ENROLLMENT FORM POLICY#70936

Administered By:

SECTION 1 – PLAN MEMBER INFORMATION ☐ ENROLLMENT ☐ CHANGE

TYPE OF CHANGE: ☐ **ADDRESS** ☐ **DEPENDENTS** ☐ **BENEFICIARY** **DATE OF CHANGE (DD/MM/YY)**

Employer's Name	Date of Membership in Directory (DD / MM / YY):	Date of Hire (DD / MM / YY):

First Name	Initials	Last Name	Occupation

Date of Birth (DD/MM/YY)	Gender: ☐ Female ☐ Male	# of Hours Worked Per Week

Address: (Street No. or P.O. Box) **(City or Town)** **(Province)** **(Postal Code)** **(Telephone #) H:_______________**

(Telephone #) C: _______________

(Telephone #) W:_______________

SECTION 2 – ENROLLMENT INFORMATION

Life, Accidental Death and Dismemberment, Dependent Life, Health and Dental (if applicable) are mandatory benefits. **(You may opt out of the Health and / or Dental Plan only if you and your dependents are insured under another plan.)**

Family coverage is mandatory if you have eligible dependents, unless covered elsewhere.

HEALTH	☐ Single	☐ Family	☐ Waive
DENTAL	☐ Single	☐ Family	☐ Waive

Do you and / or your dependents have coverage under another Health / Dental Insurance Plan? ☐ YES ☐ NO

If yes, please provide name of Insurance Company ___________________________________, Policy # _______________ and Effective Date (DD / MM / YY) ____________________. Also, if there is other coverages, who is covered:

☐ Spouse Only ☐ Spouse and yourself only ☐ Spouse and Children Only ☐ Spouse, yourself and children

SECTION 3 – SPOUSE AND DEPENDENT CHILDREN INFORMATION (if applicable)

First Name	Initials	Last Name	Spouse / Dependent	Date of Birth (DD / MM / YY)	Gender M / F	Dependent Status S-Student D-Disabled

If employee and spouse are not legally married, please provide commencement date of co-habitation (DD / MM / YY):

SECTION 4 – BENEFICIARY DESIGNATION INFORMATION (must be completed)

BASIC LIFE AND BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE.
(If a beficiary is not assigned "ESTATE" will be assumed)

Beneficiary Designation: **Relationship:**

_______________________________ _______________________________

_______________________________ _______________________________

Contingent Beneficiary (in the event the primary beneficiary (ies) named should die before you).

_______________________________ _______________________________

Please name Trustee if under age 18: ____________________________________

SECTION 5 – JOHNSON INC. USE ONLY

Effective Date of Coverage (DD / MM / YY):	Member Certificate Number

SECTION 6 - AUTHORIZATIONS & DECLARATIONS

PEI Atlantic Business Alliance I hereby apply for benefits under the PEI Atlantic Business Alliance and authorize any required bank deductions. In order to determine my eligibility for benefits and administer group benefit coverage(s), I give Johnsons (and any relevant carrier as may be applicable) consent to:

Collect and communicate personal information about me from people or organizations including: any health care practitioner, medical facility or provider of health care / dental services, any provincial health insurance plan, insurance company or reinsurer, my plan sponsor or former plan sponsor, government agency, or financial institution(s).

If applying for coverage for my spouse and / or dependents, I confirm that I have consented to collect, use and communicate their personal information for the purposes and in the manner set out above.

I acknowledge that more detailed information concerning how and why Johnson Inc. collects, uses and discloses my personal information is available at www.johnson.ca

If I have declined coverage, I understand that I may not be able to obtain coverage at a later date if I change my mind. My ability to obtain coverage is subject to the specific requirements and rules of the applicable insurance program. I am solely responsible for the decisions to decline or accept coverage reflected in this enrollment form. I understand that I may not make a claim for any loss or damage arising directly or indirectly from the elections made in this form or from my participation in the Plan against the Nova Scotia Business Directory or their successors, or any service provider, employee or agent of the Plan. In signing this form I, and my spouse if applicable, specifically release those parties from any such liability.

The information given on this form is true, correct and complete to the best of my knowledge.

_______________________________ _______________________________ ____________________

MEMBER / EMPLOYEE SIGNATURE **SPOUSAL SIGNATURE (IF APPLICABLE)** **DD MM YY**