



Group Insurance Enrollment

- New Employee
 Reinstatement

Please mail original completed form to BBD:

Western Canada
500-2755 Lougheed Highway Port Coquitlam, BC V3B 5Y9

Eastern Canada
3-55 Rideau Street Kingston, ON K7K 2Z8

Name of Employer:

▶ PLEASE PRINT. Please submit original application only – fax copies or photocopies cannot be accepted ◀

▶ Employee – Complete this section ◀

| | | | | | | | | | | |
|---|---|------------|--|------------|------------------------------|--|--|--|---|--|
| Employee Last Name | | First Name | | Initial | | Are you in Canada on a Work Visa/Permit? <i>*Copy required to enroll in plan.</i> <input type="checkbox"/> Yes <input type="checkbox"/> No | | Are you covered under your Provincial Health Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Address | | | | City | | Province of Residence | | Postal Code | | |
| Gender <input type="checkbox"/> Male <input type="checkbox"/> Female | Birth Date Month Day Year | | Language Preference <input type="checkbox"/> English <input type="checkbox"/> French | | | | | | | |
| Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Common Law* * Date of Cohabitation _____ (*Date of Cohabitation is mandatory if Common Law) | | | | | | | | | | |
| Dep. No. | List Dependents Last Name First Name Initial | | | Sex M/F | Birth Date Month Day Year | | | Relationship to You | <small>If child is over 21 years of age and attending school full-time, provide name of school. If child is handicapped, state nature of disability to apply for coverage beyond plan's age limits.</small> | |
| 01 | Spouse | | | | | | | | | |
| 02 | 1st Child | | | | | | | | | |
| 03 | 2nd Child | | | | | | | | | |
| 04 | 3rd Child | | | | | | | | | |
| 05 | 4th Child | | | | | | | | | |
| Do you have duplicate coverage under another Extended Health or Dental plan (e.g. your spouse's group plan)? If yes, provide details below: | | | | | | | | | | |
| Name of Insurance Company | | | | | | Group Number | | ID Number | | |
| <input type="checkbox"/> EHC <input type="checkbox"/> Dental | | | | | | | | | | |

Partial Waiver

The Information below must be completed for partial waiver due to coverage under another plan
I elect to waive the benefits checked below because comparable coverage is provided to me and/or my dependents under another group plan:

- ▶ For myself and my dependents..... Extended Health Care Dental Care OR
 ▶ For my dependents only..... Extended Health Care Dental Care

Is this your Spouse's group plan Yes No (If No, provide Details) _____

Beneficiary Designation

| | | | |
|---|--------------|-------------------|---|
| Beneficiary Designation (use full legal name – e.g. Mary Jane Doe, not Mrs. John Doe) I designate as revocable beneficiary in the event of my death: | | | I agree to the conditions of the contract(s) between my employer and the insurer(s) and authorize my employer to deduct required contributions from my earnings. On behalf of myself and my dependents I authorize BBD Inc. and all insurers to exchange the information detailed in this application, and any other benefit related information contained in files regarding me or my dependents, either now or in the future, for the purposes of administration and/or management of the group insurance policies issued by the insurers. I understand that this original document and all other original documents pertaining to me and my dependents are the property of BBD Inc. and will be permanently retained by BBD Inc. as required by the insurers. I confirm that the information I have provided is true and complete. |
| Full Legal Name | Relationship | Share of Proceeds | |
| Trustee Designation (complete if beneficiary is under age 18) I appoint as revocable Trustee to receive any amount which may be due my beneficiary, while such beneficiary is a minor: | | | |
| Full Legal Name | | | X Signature of Employee _____ Date _____ |

▶ Employer – Complete this section ◀

| | | | | | | | | | |
|---|-----|--------------------------------|-------|---|------|-------|---|------|-----------------|
| Employee's Earnings | | | | Hours Per Week | | | Payroll Number (optional) | | |
| \$ _____ <input type="checkbox"/> Annually <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Hourly | | | | | | | Department Number | | Employee Number |
| Employee's Occupation | | | | Class Code | | | I confirm that this employee is eligible to apply for coverage and that the information I have provided is true and complete. | | |
| Date of Employment (New Employee) | | Date of Rehire (Reinstatement) | | Effective Date (for administrator use only) | | | | | |
| Month | Day | Year | Month | Day | Year | Month | Day | Year | |
| X Authorized Signature of Employer _____ | | | | | | | Date _____ | | |