GROUP ENROLLMENT FORM 1

TO PROCESS YOUR APPLICATION, ALL APPLICABLE FIELDS ON THIS FORM MUST BE COMPLETED

Select a Plan:	☐ Prime	☐ Classic	
Select Dental Coverage:	☐ No Dental	☐ Basic Dental	☐ Enhanced Dental

If you are applying for couple or family coverage and one applicant is over age 65 and the other is not, simply tick all applicable boxes to indicate your coverage selections for both plans.

☐ I wish to be considered for the Optimum level of coverage & have included a Statement of Health form (Form 2)
☐ I wish to apply for the Essential level of coverage regardless of my guarantee (Classic only)

First Name: _____ **Last Name:** _____

Middle Initial: _____ **Date Of Birth** (MM/DD/YYYY)**:** _____ **Gender:** ☐ Female ☐ Male

Street Address: _____

Apt: _____ **City:** _____ **Province:** _____ **Postal Code:** _____

Phone: _____ **Email Address:** _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Common Law*

*Declaration For Common-Law Coverage

I the undersigned, hereby certify that I have been living with _____ since (MM/DD/YYYY) _____ and representing him/her as my spouse or my (common-law) spouse. I further certify that I and/or my (common-law) spouse are solely responsible financially for either of our children claimed for insurance purposes. I further certify that I do not have or do not wish to provide coverage for my legal spouse, if any.

For Employees Of An Endorsing Organization Only

Date Hired (MM/DD/YYYY)**:** _____ **Occupation:** _____

Organization: _____ **Phone:** _____ **Ext:** _____

Are you currently on maternity, disability or any other kind of leave? ☐ Yes ☐ No

For Association Members Only

☐ Member of Association **Date Joined** (MM/DD/YYYY)**:** _____

Association: _____ **Phone:** _____ **Ext:** _____

Are you currently on maternity, disability or any other kind of leave? ☐ Yes ☐ No

Loss of Benefits (Complete Level of Coverage Only)

Are you currently covered under your spouse's or another group benefits plan? ☐ Yes ☐ No

Provided By: _____ **Insured Through:** _____

When does or did your benefits coverage end? (MM/DD/YYYY)**:** _____

Did you lose coverage while on any type of leave (maternity, disability, etc.)? ☐ Yes ☐ No

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Request For Pre-Authorized Payment Plan (Mandatory For All Enrollments)

I hereby authorize Corsana Group Benefits to arrange automatic deductions from the following account:

Your Name As Shown On Your Account: _____

Name Of Financial Institution: _____

Street Address: _____

Unit:_____ **City:** _____ **Province:** _____ **Postal Code:** _____

Date (MM/DD/YYYY)**:** _____ **Signature:** _____

☐ **I'm applying for Classic and would like my monthly premium withdrawn on the first of the month**

Please note that we require **two cheques (NOT VOID)** to be submitted with your application and both must be made payable to **Corsana Group Benefits**. Please ensure that the cheques provided are drawn from the account listed above.
Your account must have chequing privileges

Enrollment Information For Dependants

Any dependants (including spouse) eligible for coverage must be listed below. Student refers to full-time post secondary enrollment of dependant children age 21-25.

Dependants:	First Name:	Last Name:	Gender: (M/F)	Date Of Birth: (MM/DD/YY)	Student: (Y/N)
Spouse:					
1st Child:					
2nd Child:					
3rd Child:					
4th Child:					

Enrollment Acknowledgment

I hereby enroll for the benefit coverage from Corsana Group Benefits for which I am eligible, and I authorize the association/organizationl to release my address, phone and income information to the plan administrator if required. I acknowledge all information is complete and accurate. I understand that I and my dependants must be covered under a provincial health plan and that I (retirees excluded) must be actively working in order to be eligible for coverage. I understand that the health evidence provided by me and my dependants as part of this enrollment may be used by all parties involved in the issuing of my coverage and I hereby consent to such usage on behalf of myself and any dependants for whom coverage is sought. I understand that Corsana Group Benefits reserves the right to audit claims. I understand that coverage is effective on the first of the month following the date that my enrollment is received, unless I elect to delay the effective date one month, provided all the requirements have been met:

- A fully completed, signed enrollment and required premium has been received
- Underwriting approval for instances where underwriting is required
- I continue to meet all eligibility rules

I acknowledge that it is my sole responsibility to inform Corsana Group Benefits of any changes in my status or otherwise in the event that it may affect my eligibility for coverage, and that failure to do so may result in premiums paid when coverage is not required and refunds under these circumstances will not be made.

Date (MM/DD/YYYY)**:** _____ **Signature of Applicant:** _____