HEALTH CARE PROVIDERS GROUP ENROLLMENT FORM

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

CHOOSE YOUR COVERAGE:

If you are applying for couple or family coverage and one applicant is over age 65 and the other(s) is not, simply tick the applicable boxes in both columns to indicate your coverage selection in both plans.

Select a Plan	☐ Plan 1A	☐ Plan 1	☐ Plan 2	☐ Plan 65+
Select Dental Coverage	☐ No Dental	☐ Basic Dental	☐ Enhanced Dental	

Plan 1 & 2 ONLY: ☐ I do not wish to apply for coverage other than what I am guaranteed
Plan 65+ ONLY: ☐ I wish to apply for the essential level of coverage regardless of my guarantee

LAST NAME: _____ **FIRST NAME** _____ **MIDDLE INITIAL**___

_____/_____/_____/_____
ADDRESS CITY PROVINCE POSTAL CODE

HOME TELEPHONE: (____)_____ **EMAIL ADDRESS:** _____

MALE ☐ **FEMALE** ☐ **DATE OF BIRTH**: (DD/MM/YYYY) _____/_____/_____

SINGLE ☐ **MARRIED** ☐ **COMMON LAW** (SEE DECLARATION OVERPAGE) ☐ **SEPARATED** ☐ **DIVORCED** ☐ **WIDOWED** ☐

DEPENDENTS ENROLLMENT INFORMATION

ANY DEPENDENTS (Incl. spouse) ELIGIBLE FOR COVERAGE UNDER THIS PLAN MUST BE LISTED BELOW

Dependents	Surname	First Name	M/F	DOB (dd/mm/yyyy)	Full Time Student (Y/N) (age 21-25)
Spouse					
1st Child					
2nd Child					
3rd Child					
4th Child					

FOR EMPLOYEES ONLY (CURRENT POSITION)

PART TIME ☐ **CASUAL** ☐ **TEMPORARY** ☐ **CONTRACT** ☐

Date hired: (dd/mm/yyyy) _____/_____/_____

Are you currently on maternity, disability or any other kind of leave?
YES ☐ **NO** ☐

Average weekly hours: _____ Gross monthly salary: $_____

Occupation:_____

Hospital: _____

Hospital Tel: _____ Ext. _____

FOR RETIREES ONLY

RETIRED FROM HOSPITAL ☐

Date Retired :(dd/mm/yyyy) _____/_____/_____

Last date actively work at hospital: (dd/mm/yyyy)
_____/_____/_____

Have you retired while on Disability or other kind of leave?
YES ☐ NO ☐

Are you currently collecting **ANY** Long Term Disability benefits?
YES ☐ NO ☐

Hospital: _____

Are you currently or have you, within the past 60 days, been covered by a group health plan?

IF YOU ANSWERED "YES", PLEASE COMPLETE THE NEXT LINE

PROVIDED BY: _____ **INSURED THROUGH:** _____
Name of employer or other provider Name of Insurance Company

Complete beneficiary and/or trustee information only if you are applying for Plan 1 or 1A

BENEFICIARY: _____

TRUSTEE : _____
(Name a Trustee if beneficiary is under age 18. Will expire when beneficiary reaches age 18)

***APPLICATION FOR COMMON-LAW COVERAGE – DECLARATION**

I the undersigned, hereby certify that I have been living with _____ since (dd/mm/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 I do not wish to provide coverage to my legal spouse, if any.

REQUEST FOR PRE-AUTHORIZED PAYMENT PLAN

(NOTE: YOUR ACCOUNT MUST HAVE CHEQUING PRIVILEGES)
I hereby authorize Health Care Providers to arrange automatic deductions from the following account:

Your name as shown on the account:
_____

Name of your Bank:
_____

Address of Bank: _____ City: _____ Postal Code: _____

Date: _____ Signature: **X** _____
(dd/mm/yyy)

*Two (2) cheques are required with your application; please make them both payable to **HCP Group Insurance.** Also please ensure that these two (2) cheques are drawn on the account from which you wish us to withdraw your monthly premium.*

☐ ***I am applying for Plan 65+. I request that my withdrawal dates be on the first day of the month.***

I hereby apply for the benefit coverage from the Health Care Providers Group Insurance Plan™ for which I am eligible, and I authorize the hospital to release 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 dependents must be covered under my Provincial Health Plan in order to be eligible for Extended Health coverage. I understand that the Health evidence provided on me and my dependents as part of this application 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 dependents for whom coverage is sought. I understand that Health Care Providers Group Insurance Plan™ reserves the right to audit claims.
I understand coverage is effective on the first of the month following the date my application is approved, unless I elect to delay the effective date one month provided all of the following requirements have been met:

- A fully completed signed application and required premium has been received by Hardiman Mount & Associates Insurance Brokers Limited
- Underwriting approval (when underwriting is required)
- I continue to meet all eligibility rules

I understand that, *unless I am a retiree*, I must be actively at work on the effective date of coverage or coverage will be delayed until the first of the month following my return to active employment.

Date _____ **Signature of Employee:** **X** _____

Privacy Statement
All information about the insurability of you and your dependents is considered confidential. HCP is a business name registered to Hardiman Mount & Associates Insurance Brokers Limited and we are committed to protecting the privacy, confidentiality, accuracy and security of the personal information that is collected, used, retained and disclosed in the course of conducting business.