GROUP ENROLLMENT FORM 1

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

Select a Plan:	☐ Plan 1A	☐ Plan 1	☐ Plan 2	☐ Plan 65+
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 (Plan 65+ 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*

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:					

For Employees Only (Current Position)

☐ Part-Time ☐ Casual ☐ Contract ☐ Temporary **Date Hired** (MM/DD/YYYY)**:** _____

Occupation: _____ **Gross Monthly Salary:** _____ **Average Weekly Hours:** _____

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

Hospital: _____ **Phone:** _____ **Ext:** _____

For Retirees Only

☐ Retired From Hospital **Date Retired** (MM/DD/YYYY)**:** _____ **Hospital:** _____

Last Day Actively Worked At The Hospital (MM/DD/YYYY)**:** _____

Have you retired while on a disability or any other kind of leave? ☐ Yes ☐ No

Are you currently collecting ANY long term disability benefits? ☐ Yes ☐ No

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

I hereby authorize Health Care Providers 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 Plan 65+ 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 **HCP Group Insurance**. Please ensure that the cheques provided are drawn from the account listed above.
Your account must have chequing privileges

Beneficiary Designation (For Plan 1A & Plan 1 Applicants Only)

Beneficiary: _____ **Relationship To Insured:**_____

Trustee (Must Name A Trustee If Beneficiary Is Under 18 Years of Age)**:** _____

Proof of Coverage (For Plan 1A Applicants Only)

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

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

*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.

Enrollment Acknowledgment

I hereby enroll for the benefit coverage from Health Care Providers Group Insurance Plan™ for which I am eligible, and I authorize the hospital 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 Health Care Providers Group Insurance Plan™ 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 Health Care Providers Group Insurance Plan™ of any changes in my work hours, 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 Employee:** _____

PRIVACY: All information about the insurability of you and your dependants is considered confidential. Health Care Providers Group Insurance Plan™ is a business name registered to HMA The BENEFITS People 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.