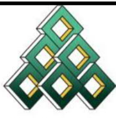

GROUP INSURANCE PLAN
ENROLLMENT FORM

Administered by:

Check (ü)

☐ **CIVIL SERVICE** ☐ **DEPT. OF HEALTH** ☐ **EXC SUP/CONF EES OF SCH BDS**
☐ **IWMC** ☐ **EISI** ☐ **WORKERS COMPENSATION BOARD**
☐ UPSE ☐ CUPE ☐ PEINU ☐ IUOE ☐ EXCLUDED ☐ NON-UNION

☐ **ENROLMENT** ☐ **CHANGE:** **CHANGE DATE:** _____
☐ Full-Time ☐ Name ☐ Termination
☐ Part-Time ☐ Address ☐ Reinstatement
☐ Dependents ☐ Other: _____

MEMBER INFORMATION				
(First Name) (Initials) (Last Name)				Member No.
Date of Birth (DDMMYY)	Date of Hire (DDMMYY):		Gender: ☐ Female ☐ Male	
Address: (Street No./P.O. Box)	City or Town	Province	Postal Code	
Home Tel:	Work Tel:	Cell:	E-mail:	

DEPENDENT INFORMATION
To ensure you are enrolled for all benefits for which you are eligible, you must report any change to spousal/dependent status to Johnson Inc. within 31 days of the change.
Include Last Name if different from your last name
(last, first, initial)

Spouse / Child Name - must be completed if you have a spouse and/or dependent children. If employee and spouse are not legally married, please provide commencement of date of co-habitation (DD / MM/ YY): ___________	Date of Birth (DD / MM / YYYY)	Gender M/F	Dependent Status S- Student D -Disabled
Spouse:			
Child:			
Child:			
Child			
Child			

APPLICATION INFORMATION

Basic Life and Basic Accidental Death & Dismemberment Insurance are mandatory for all eligible employees.

Health:	☐ Single	☐ Family	☐ Declined
Dental Basic Services Only:	☐ Single	☐ Family	☐ Declined
Dental – Basic & Major Restorative:	☐ Single	☐ Family	☐ Declined
Travel:	☐ Single	☐ Family	☐ Declined

Do you and /or dependents have coverage under another Health or Dental Plan? ☐ Yes ☐ No. If yes, please provide: Effective date (DD / MM/ YYYY):___________ Insurance Company and Policy No.______________________

Basic Dependent Life ($4,000 Spouse / $3,500 per child): ☐ Yes ☐ Declined

Optional Life Insurance: *(First $30,000 of coverage is available without medical evidence during eligibility period.)*.

☐ Employee Coverage ($30,000) Plus Additional Amount Requested: __________ ☐ Declined

☐ Spousal Coverage ($30,000) Plus Additional Amount Requested: __________ ☐ Declined

☐ Dependent Child $10,000 per dependent child ☐ Declined

Voluntary Accidental Death & Dismemberment Coverage: *(No individual may be covered more than once under the Voluntary AD&D Plan. If you are covered as an employee, you cannot be covered as a spouse or dependent child of another employee who is also covered under the Plan).*

☐ Employee Only ☐ Employee-Children ☐ Family Amount Applied For: ☐ Declined

If requesting family coverage, please provide spouse's employer:

Optional Critical Illness: (First $50,000 of coverage is available without medical evidence. Amounts above $50,000 will require an Evidence of Insurability form to be completed. Available in units of $10,000 to a maximum of $250,000)

Employee Coverage Smoker ☐ Non-Smoker ☐	Amount:	Declined: ☐
Spousal Coverage: Smoker ☐ Non-Smoker ☐	Amount:	Declined: ☐

AUTHORIZATION & DECLARATIONS

I hereby apply for benefits under the Public Sector Group Insurance Plan Benefit Plan and authorize any required payroll / bank deductions and consent to the use of my Social Insurance Number, if required, for the purpose of tax reporting, identification, or record keeping under the Plan.
To determine my eligibility for benefits and administer group benefit coverage(s), I give Johnson Inc. (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 have consent to collect, use and communicate their personal information for the purposes listed 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 enrolment 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 Public Sector Group Insurance Plan Benefit Plan, the Public Sector Group Insurance Trustees or their successors, or any service provider, employee or agent of the Plan or the Trustees. 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.

EMPLOYEE SIGNATURE SPOUSAL SIGNATURE (IF APPLICABLE) DD / MM / YYYY