Public Sector Group Insurance Trustees

GROUP INSURANCE PLAN ENROLLMENT FORM RETIREE

Administered by: JOHNSON

Check (X) ☐ **HEALTH SECTOR** ☐ **CIVIL SERVICE**

☐ **RETIREMENT** ☐ **CHANGE TO RETIREMENT COVERAGES**

Retirement Date: _____ (DD MM YY) **Effective Date of Change:** _____ (DD MM YY)

RETIREE INFORMATION

(First Name)	(Initials)	(Last Name)
Date of Birth (DD/MM/YY)	**Gender:** ☐ **Female** ☐ **Male**	**Payroll No.**
Address: (Street No./P.O. Box)	**City or Town** / **Province** / **Postal Code**	**Telephone No.**

BASIC COVERAGES

Basic Life Insurance - $5,000 benefit (no cost to the retiree).

Basic Accidental Death & Dismemberment and Dependent Life Insurance – Please refer to your Employee Booklet.

OPTIONAL COVERAGES

Health					
- Option 1	☐ Enroll	☐ Decline	Travel:	☐ Enroll	☐ Decline
- Option 2	☐ Enroll	☐ Decline	* Optional Life Insurance:	☐ Continue	☐ Decline
- Option 3	☐ Enroll	☐ Decline	* Spousal Life Insurance:	☐ Continue	☐ Decline
- Option 4	☐ Enroll	☐ Decline	* Voluntary AD&D:	☐ Continue	☐ Decline
			*** Volume of coverage cannot be increased after retirement.**		
Dental:					
Basic Service Only:	☐ Enroll	☐ Decline	Basic Dependent Life:	☐ Continue	☐ Decline
Basic & Major Restorative:	☐ Enroll	☐ Decline	Optional Dependent Life:	☐ Continue	☐ Decline

Optional Employee Life, Optional Spousal Life, Optional Dependent Life and Voluntary AD&D terminate at age 65.

AUTHORIZATIONS & 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.

In order 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 enrollment 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 / YY**