REVISED CARD – CHECK HERE ☐

FOR OFFICE USE ONLY

# *B.C. MARINE INDUSTRY EMPLOYEE HEALTH BENEFIT PLAN*

## *GROUP INSURANCE ENROLMENT FORM*

Please complete in ink and print clearly. Please fill in all information and ensure you have signed and dated this form.

**EMPLOYEE INFORMATION**

| EMPLOYEE'S SURNAME | FIRST | INITIAL | SOCIAL INSURANCE NUMBER |
|---|---|---|---|
| | | | |

| ADDRESS (No. and Street) | CITY | PROVINCE | POSTAL CODE |
|---|---|---|---|
| | | | |

| MARITAL STATUS | MALE/FEMALE | DATE OF BIRTH (Year, Month, Day) | PHARMACARE REGISTRATION NO. (where applicable) |
|---|---|---|---|
| | | | |

**MARITAL STATUS DECLARATION - Refer to other side for the definition of an eligible Spouse**

I hereby certify that I have read the 'Definition of Spouse' and that as of the date of this declaration, I have a Spouse as follows:

| SPOUSE'S NAME (if common-law see reverse) (Surname, First Name & Initials) | MALE/FEMALE | DATE OF BIRTH (Year, Month, Day) | DATE OF MARRIAGE (OR DATE OF COMMENCEMENT OF COMMON-LAW RELATIONSHIP) |
|---|---|---|---|
| | | | |

**DEPENDENT INFORMATION (Other than Spouse) –** List all eligible dependents, other than your Spouse, starting with the eldest. If adding children over 21, indicate the school they are attending Full-time.

| NAME (Surname, First Name & Initials) | RELATIONSHIP (Son/Daughter) | DATE OF BIRTH (Year, Month, Day) | STUDENT (Yes/No) and name of school, if over 21 |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**CO-ORDINATION OF BENEFITS**

Are you covered by another benefit plan (ie your Spouse's plan)? YES ☐ NO ☐ If YES, indicate the benefits covered:

Benefits _____ Policy No(s)_____ Insurance Carrier _____

**If you or your dependents do not require all benefits provided by your group insurance plan, you must complete the waiver on the reverse side of this form.**

**GROUP LIFE INSURANCE BENEFICIARY DESIGNATION**

I designate the following individual(s)* as my revocable group life insurance beneficiary(ies), if living, otherwise my Estate* and revoke any prior designation I have made. *Indicate Estate, if no named beneficiary.

| NAME (Surname, First Name & Initials) | RELATIONSHIP | |
|---|---|---|
| | | % |
| | | % |

**TRUSTEE CLAUSE: If appointing a minor beneficiary, complete the following (Trustee must be of legal age):**

I designate the following trustee to receive and disburse any monies payable under this group policy to my beneficiary(ies) during minority, and any payments made to this trustee will release the insurer of any further liability:

_____ _____

Trustee's Full Name | Relationship to Employee

**APPLICATION FOR ENROLMENT**

I, the undersigned, hereby:

a) apply to be enrolled in the B.C. Marine Industry Employee Health Benefit Plan,
b) certify that the information provided on this form is correct,
c) consent to the collection, use and disclosure of my personal information by the Trustees of the Plan (or its authorized agent) for the purpose of administering the Plan and the benefits that may be conferred on members of the Plan,
d) agree to be bound by all the terms and conditions of the Plan,
e) **agree to promptly update my Employer and the Plan Administrator on any changes to the status of a Spouse, dependent or beneficiary,** and agree that I am liable for any benefit paid out incorrectly in the event that I have not updated my Employer and the Plan Administrator on any change to the status of a Spouse, dependent or beneficiary,
f) understand that completion of this form does not in itself, entitle a Member to benefits – qualification for benefits is in accordance with the rules of the Plan, and
g) **certify that I have read the information provided on the reverse side of this form**.

_____ _____

**SIGNATURE OF MEMBER** | **DATE**

**EMPLOYER'S STATEMENT**

| NAME OF EMPLOYER | EMPLOYER'S AUTHORIZED SIGNATURE |
|---|---|
| | |

| EMPLOYEE'S DATE OF EMPLOYMENT (or return to work) | NEW ☐ REHIRED ☐ LATE APPLICANT ☐ | EMPLOYEE'S CLASS/ DIVISION | EMPLOYEE'S OCCUPATION |
|---|---|---|---|
| | | | |

| EMPLOYEE'S EARNINGS | HOURLY ☐ MONTHLY ☐ ANNUALLY ☐ | HOURS WORKED PER WEEK |
|---|---|---|
| | | |

**EMPLOYEE IDENTIFICATION**

| EMPLOYEE SURNAME | FIRST | INITIAL | SOCIAL INSURANCE NUMBER |
|---|---|---|---|
| | | | |

**REFUSAL – WAIVER OF BENEFITS**

I understand the Plan of Group Benefits offered to me. However, if permitted by the provisions of the Plan, I **decline** to participate in:

☐ Dental ☐ Extended Health (may include Vision Care) ☐ Other (specify) _____

☐ for myself ☐ and/or for my dependents

☐ Comparable coverage is provided for me and/or my dependents under my Spouse's plan:

Name of Insurer _____ Policy No. _____ Certificate No. _____

I agree that if at a later date I wish to participate in the insurance hereby refused, I must submit, at my own expense, evidence of insurability for myself and any dependents for whom application for coverage is made. However, if I have refused Health/Dental Insurance because of other group coverage, such evidence of insurability will not be required provided the alternate coverage terminates and I apply for Health/Dental Insurance within 31 days of the termination date.

**DEFINITION OF SPOUSE - if you are indicating a spouse on the reverse side (page 1), under MARITAL STATUS DECLARATION, they must meet the following definition:**

*The B.C. Marine Industry Employee Health Benefit Plan defines "Spouse" as:*

*The legal spouse of the Employee, or, in the absence of a legal spouse, the common-law spouse of the Employee. The common-law spouse is a person with whom the Employee has been living with and that living arrangement must be recognized as a conjugal relationship in the community in which the couple resides. Only one person may qualify as the spouse at any one time. Common-law spouses must meet the Plan's minimum co-habitation rule.*

**COMMON-LAW DEPENDENTS**

*Common-law spouses and their children **may be** eligible with a minimum co-habitation period as indicated in your group policy. NOTE: Only the children of your Common-Law Spouse who are residing with you are considered eligible dependents.*

**COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION**

*The collection, use and disclosure of an individual's personal information by the Board of Trustees of the Plan (or the Trustees' authorized agent, including the Plan Administrator) during his/her participation in the Plan is for the purpose of administering the Plan and the benefits that are conferred on members of the Plan. The collection, use and disclosure of personal information about individual members of the Plan will be done in a manner that is reasonable. Furthermore, reasonable security arrangements will be taken to prevent any unauthorized access, collection, use, disclosure, copying, modification or disposal of personal information about individual members of the Plan.*

**PRIVACY QUESTION**

In order to verify your identity when you call the Plan Administrator, please provide a personal fact or question along with the answer that only you would be able to answer (mother's maiden name, place of birth etc.):

**Question**:_____

**Answer:**_____

ADMINISTRATOR:
**Convyta Partners**
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Toll-Free 1-877-627-4630 Fax: (604) 299-8136
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