GROUP INSURANCE ENROLLMENT FORM

Group Policy No.	Certificate No.	Occupation:	Male ☐ Female ☐	Mr. ☐ Mrs. ☐ Ms. ☐
First Name		Middle Name	Last Name	
Address:				
Telephone No: Home: Work:	Date of Birth: Day / Month / Year	Coverage: ☐ Life ☐ Health	No. of Dependents including Spouse?	
Marital Status: ☐ Single ☐ Married ☐ Common Law	Do you wish to cover your Dependents? ☐ Yes ☐ No	Beneficiary:	Relationship:	

BENEFICIARY WITNESSES – (Required if Beneficiaries are listed)

1. Name: ____________________ Signature ____________________
2. Name: ____________________ Signature ____________________

I reserve the right to change the beneficiary appointed above subject to any statutory reasons. If the Group Insurance Plan provides that any contributions be made by me, I authorize my employer to deduct them from my pay.

____________________ ____________________
Date Signature

TO BE COMPLETED BY EMPLOYER – SHOULD BE THOUROUGHLY COMPLETED

		EARNINGS	This employee has been continuously employed by us since the date of his/her employment shown and is at present working a minimum of 30 hours per week for full pay.
First Employed	Day / Month / Year	☐ Weekly	
Date Appointed	Day / Month / Year	☐ Monthly	
End of Waiting Period	Day / Month / Year	☐ Annually	
Effective Date of Insurance	Day / Month / Year	Salary ____________	Company Stamp & Administrator Signature

DEPENDENTS TO BE INSURED

1 = Spouse **2 = Common Law Spouse** **3 = Son** **4 = Daughter** **5 = Stepson** **6 = Stepdaughter**

Name	Date of Birth	Relationship	Address
	Day / Month / Year		
	Day / Month / Year		
	Day / Month / Year		
	Day / Month / Year		
	Day / Month / Year		
	Day / Month / Year		
	Day / Month / Year		
	Day / Month / Year		