Enrolment form

COMPLETE THIS FORM FOR THE ADDITION OF A NEW PLAN MEMBER

- Section **1** is to be fully completed by the Plan Sponsor/Employer.
- Sections **2 - 6** are to be fully completed by the Plan Member/Employee.
- Return the **original form** to the Plan Sponsor/Employer; make a copy for your records. Plan Sponsor/Employer to keep **original** in Employee file.
- Submit a **copy** of your **completed form** to the attention of the Client Service Centre by email or fax.
  Email: csc@telushealth.com; **Fax**: 1.877.464.0109
- Be sure to submit to your Plan Sponsor/Employer and TELUS Health within 31 days of the effective date of enrollment. If not, you and your dependents may be required to provide proof of insurability, and your benefits may be limited or denied.

1 Plan Sponsor/Employer Information

Client name		Client/division code	Class
Cost centre (if applicable)	Employee hire/re-hire date Y Y Y Y / M M / D D	Employee effective date Y Y Y Y / M M / D D	Plan member ID #
Insurance company name(s) A)		Policy/group contract numbers	Occupation
B)		Policy/group contract numbers	Waiting period
C)		Policy/group contract numbers	Annual salary
Employment status ◯ Full time ◯ Part time ◯ Seasonal/contract ◯ Other:			Hours worked per week

2 Plan Member/Employee Information

Last name	First name	Middle initial	Gender ◯ M ◯ F
Marital status ◯ Single ◯ Married ◯ Separated ◯ Widowed ◯ Divorced ◯ Civil union ◯ Common law*		* Date of cohabitation for common law Y Y Y Y / M M / D D	
Mailing address	City	Province	Postal code
Email Address	Phone Number	Birth date Y Y Y Y / M M / D D	

3 Plan Member/ Employee Coverage and Family Information *(Please list all of your eligible dependants, even if you select single coverage.)*

Do you have a spouse and/or dependant(s)? ◯ Yes ◯ No	Required health coverage ◯ Single ◯ Couple ◯ Family	Required dental coverage ◯ Single ◯ Couple ◯ Family		
Spouse's last name	Spouse's first name	Spouse's birth date Y Y Y Y / M M / D D	Spouse's gender ◯ M ◯ F	
Does your spouse have benefits through an employer plan? ◯ Yes ◯ No		If yes, please provide carrier/policy #:		
If yes, please indicate spouse's coverage:	Health ◯ Single ◯ Couple ◯ Family	Dental ◯ Single ◯ Couple ◯ Family		
Child's full name (last, first)	Birth date Y Y Y Y / M M / D D	Gender ◯ M ◯ F	Student ◯ Yes ◯ No	Disabled** ◯ Yes ◯ No
Child's full name (last, first)	Birth date Y Y Y Y / M M / D D	Gender ◯ M ◯ F	Student ◯ Yes ◯ No	Disabled** ◯ Yes ◯ No
Child's full name (last, first)	Birth date Y Y Y Y / M M / D D	Gender ◯ M ◯ F	Student ◯ Yes ◯ No	Disabled** ◯ Yes ◯ No

*To add a common law spouse, you are required to have been living in a common law relationship for a period of at least 12 consecutive months.

**For disabled dependants, please complete an *Application for total and permanent disability status of a dependant child* form.

ARBG-F1000-ENROL-10192023-EN

Dependant children are generally those who are dependent on the employee for financial care and support. Eligibility for dependents is up to a certain age and may be continued when the child is a full time student. **Disabled dependants may be eligible for benefits coverage**. Check with your plan sponsor/employer for further information as dependent eligibility can vary depending on the benefit plan.

4 Waiver of Benefits

If you waive health and/or dental coverage and later lose coverage through another plan, you may apply for benefits under this plan within 31 days. Otherwise you and/or your dependants may be required to provide proof of insurability, and your benefits may be limited or denied under this plan.

If you or your dependants are presently covered for health and/or dental benefits under another benefits plan you may be able to waive coverage for such benefit(s) under this plan.

I waive coverage for myself and my dependents under: ☐ Health ☐ Dental

I waive coverage for my dependents only under: ☐ Health ☐ Dental

5 Plan Member/Employee Beneficiary Information**

If you designate a beneficiary who is:

(a) under the age of majority, or

(b) mentally incapacitated

you should also designate a Trustee for that beneficiary. If this situation applies to you or you have concerns about your named beneficiary's legal status, please consult a legal advisor for further details.

*If you are a Quebec resident and you designate your spouse as a beneficiary, you are not permitted to change that beneficiary unless you:

(a) indicate that your designation of beneficiary is revocable, by checking the box on this form, or

(b) your spouse agrees, in writing, to be removed as your beneficiary.

**If you are a resident of a province other than Quebec, your beneficiary designation is automatically revocable unless you specifically make it irrevocable. If you make an irrevocable beneficiary designation, you will not be able to alter or change your beneficiary designation in any way without the consent of the beneficiary. If your beneficiary is a minor, you will not be permitted to alter or change your beneficiary designation in any way until your beneficiary reaches the age of majority. You should consider obtaining legal and financial advice from a professional advisor before making any irrevocable beneficiary designation.

Original beneficiary information will be kept by your plan sponsor/employer.

Name Your Beneficiary or Beneficiaries

Name of Beneficiary (last/first/middle)	Relationship to Plan Member	Beneficiary Revocable?**	Percent Allocated
		○ Yes ○ No	%
		○ Yes ○ No	%
		○ Yes ○ No	%
		○ Yes ○ No	%
	Total value must equal 100%		Total 0 %

I appoint _____ as trustee to receive any amount designated to a beneficiary who is under the age of majority or mentally incapacitated.

In the event the primary beneficiary or beneficiaries predeceases the plan member, the following contingent beneficiary or beneficiaries shall be entitled to the benefits:

Name of Contingent Beneficiary (last/first/middle)	Relationship to Plan Member	Beneficiary Revocable?**	Percent Allocated
		○ Yes ○ No	%
		○ Yes ○ No	%

For Quebec residents only*

If you have designated your spouse as beneficiary, the designation will be irrevocable, unless you indicate that you wish it to be revocable below.

I wish to make my designation: ○ Revocable ○ Irrevocable

6 Plan Member/Employee Declaration

I consent to the collection, use, and exchange of my personal information by my plan sponsor/employer or the administrator, an insurance company, and/or others who require information to administer my group benefits.

I authorize these parties to obtain and exchange between them, any information about me, my spouse, and my dependant children to determine benefit entitlements, and for record keeping, file identification, reporting, underwriting, procurement of health information, claims adjudication and resolution, program management, and other services provided from time to time.

I confirm that I have obtained consent from my spouse and any dependant children over the age of majority, to share information as it relates to the plan.

In the case of death, I expressly authorize my employer, the policyholder, the beneficiary, heir, or liquidator of my estate to provide the insurance companies, when required by the latter, with all the information and authorizations permitting the assessment of the claim and the collection of evidence.

I hereby apply for group benefits under my plan sponsor's/employer's plan and authorize any required deductions.

I certify that the information given above is true and complete. A photocopy of this authorization is as valid as the original. The original enrolment form will be retained by my plan sponsor/employer.

Plan member/employee signature _____ Date signed _____

Plan administrator signature _____ Date signed _____