ABC BENEFITS

EMPLOYEE ENROLLMENT FORM

For Office Use Only

Policy No. _____

Class _____

Eff. Date _____

Employee Information

Employee's Last Name	First Name	Birth: Year / Month / Day	Sex: M / F
		/ /	

Home Address	City / Town	Province	Postal Code

Home Phone	Date of Hire	Marital Status	Occupation

Name, Address & Phone Number Of Your Workplace	Annual Salary

Indicate ☑ Your Level Of EHC/Dental Coverage: ☐Single ☐Couple ☐Family ☐ Single Parent ☐*Waiver

*Waiver can only apply if Spousal Coverage exists, as noted under Dependent Information.

If applying for "Couple", "Family" or "Single Parent" Coverage, please complete the "Dependent Information" section below.

Dependent Information

Spouse's Last Name	First Name	Birth: Year / Month / Day	Sex: M / F
		/ /	

If your Spouse is covered under any other Health Care and/or Dental Care plan, please provide the following information:

Spouse's Employer or Name Of The Other Plan _____

Plan Policy # _____ Insurance Company Name _____

If any of your Dependent Children are age 21 or over, indicate whether the Child is a Student "S" or Disabled "D". Students 21 and over must provide proof of attendance at an accredited school (i.e. a copy of their student card).

Child's Last Name	First Name	S or D	Birth: Year / Month / Day	Sex: M / F
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	

COMPLETE BOTH SIDES OF THIS EMPLOYEE ENROLLMENT FORM IN FULL

PLEASE ENSURE YOUR SELLING AGENT RETURNS ALL COMPLETED DOCUMENTATION TO:

MACDONALD ADMINISTRATION

ABC BENEFITS c/o MACDONALD BENEFIT SERVICES

100 Cowdray Court, Suite 200, Toronto, Ontario, M1S 5C8

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Beneficiary Designation

This beneficiary designation applies only to Life Insurance benefits as purchased, and is revocable unless prohibited by law. If there is more than one beneficiary, the total amount must not exceed 100%.

Beneficiary's Last Name	First Name	Relationship	% Amount

Beneficiary's Last Name	First Name	Relationship	% Amount

Notice Regarding The Opening Of A Personal Information File

All personal information that Macdonald Administration Services (MAS), and/or other participating Insurer(s) has or will have regarding you will be kept confidential in a file opened for the purpose of offering you insurance and other related financial services. Access to your file will be restricted to employees who must consult it in the course of their duties.

You may access your file and ask that the information it contains be corrected, provided you can demonstrate that this information is inaccurate, incomplete, ambiguous, out-of-date or unnecessary. You may consult your file with the person in charge of protection of personal information at MAS, and/or other participating Insurer.

Declaration and Authorization for the Collection of Personal Information

I hereby declare that the information given in this entire Application For Insurance, is true and complete to the best of my knowledge and belief. I understand that the coverage applied for under this plan is subject to the approval of the plan underwriters, and may be declined based on their medical insurability guidelines. Coverage will commence only after I have received written notification of my acceptance from the plan administrator, Macdonald Administration Services.

I hereby acknowledge that I have read the "Notice Regarding The Opening Of A Personal Information File".

I hereby authorize any licenced physician, medical practitioner, hospital, clinic, or other medically related facility or pharmacy, insurance company or financial institution, Revenue Canada, the Medical Information Bureau, any personal information agent, investigative and law enforcement agency, agent, broker, employer, former employer, and any government agency or other organization or person that has any record or knowledge of me or my health to provide and exchange such information with the plan underwriters or their reinsurers, for the purpose of this Application For Insurance, its administration, any modification or reinstatement thereof, and any subsequent claim, as required.

Signed at: _____ (City / Town) , _____ (Province) this _____ (Date) day of _____ (Month) , _____ (Year)

Applicant's Signature: _____

Spouse's Signature: _____