ELCIC Group Benefits
Plan Enrollment Form

Member			
First name		Last name	

Member Contact Information			
Personal email			
Street address			
City, Province		Postal Code	
Home phone		Mobile phone	

Member Personal Information			
Date of birth dd/mm/yyyy		Gender	
Marital status		Date of marriage/co-habitation dd/mm/yyyy	

Member's Family Information			
Spouse's first name		Spouse's last name	
Date of birth dd/mm/yyyy		Gender	
Spouse – the person to whom you are legally married; or a person continuously living with you in a role like that of a marriage partner for at least one year.			

Dependent Child First name	Dependent Child Last name	Gender	Date of Birth dd/mm/yyyy	If over age 21 is child a student?
Dependent Child – your natural or legally adopted child, (dependent on you or your spouse for financial support), or step child, who is: unmarried; under age 21, or under age 25 and a full-time student; not employed on a full-time basis; and not eligible for insurance as an employee under this or any other group benefit program.				

Date of Enrollment	
Date of hire or eligibility met dd/mm/yyyy	
If you have recently arrived in Canada, please indicate the date of your provincial health coverage. Note that your extended health benefit will start effective as of this date.	

Benefits Modules

The ELCIC Group Benefits Plan offers member the choice between three modules, each comprising different levels of benefits coverage. The coverage details can be reviewed on the GSI website. You will be automatically enrolled in the **Blue** module upon meeting eligibility. Alternatively, you may select to increase your benefits coverage by enrolling in either the Green or the Teal module.

☐ **Blue** ☐ **Green** ☐ **Teal**

Please advise your employer of your selection and confirm who is responsible for the difference in premium. If it is your responsibility then payment is made by payroll deduction.

Coordination of Benefits

Does your spouse have health and dental benefits plan through a current employer that includes coverage for you and your dependents?

☐ **No** ☐ **Yes** If yes please indicate for which ☐ **health** ☐ **dental**

If **yes**, you will be coordinating your benefits with those of your spouse. Coordination of benefits allows for reimbursement of insured expenses from both yours and your spouse's plans, up to a total of 100% of the actual expenses incurred.

Spouse's benefits insurer		Effective date of spouse's coverage	
Spouse's insurance plan number		Spouse's member number	

Life Insurance Beneficiary

First name	Last name	Date of birth dd/mm/yyyy	Address	Relationship	% share

Contingent Beneficiary

You may wish to designate a contingent beneficiary(ies) to receive your account entitlement if all the primary beneficiary(ies), named above should die before you. In that event, a contingent beneficiary will automatically be entitled to the benefit that would have been payable to the primary beneficiary(ies). If you have not named a contingent beneficiary, then your estate becomes the contingent beneficiary.

First name	Last name	Date of birth dd/mm/yyyy	Address	Relationship	% share

Trustee Appointment for Minors

Trustee appointment for minors – please complete if any beneficiaries are under 18 years of age

First name	Last name	Phone number	Address	Relationship

If living, shall be and is hereby appointed trustee to receive and disburse any monies payable hereunder to child(ren) aforesaid during minority, or failing such trustee, to the duly appointed guardian of such minor child(ren) as trustee. Payment so made to said trustee shall discharge the payer to the extent of such payment.

Authorization and Acknowledgements

I certify the information contained herein is correct**.** I request my employer to arrange for the issuance of group coverage for which I am eligible. I understand that if I have a spouse and/or eligible dependents, I will automatically be enrolled with family coverage. I authorize my employer to deduct from my earnings the premiums, if any, required for the coverage.

I consent to the collection, use and disclosure by ELCIC Group Services Inc. (GSI) of my personal information, including without limitation the information provided in this form, in accordance with GSI's Privacy Policy, including without limitation for the purpose of activities related to my enrollment in and ongoing eligibility for this group benefits plan, the efficient administration of my entitlements under the benefits plan, and the management of my participation in the benefits plan.

I consent to GSI disclosing and/or obtaining information to and from the subscribing employer, and to its agents and service providers, including, but not limited to insurers, benefits providers or administrators and benefits consultants, for these purposes.

I am authorized to release information concerning my spouse and my dependents.

I hereby revoke all previously designated beneficiaries and appoint the aforesaid to receive any benefits payable in the event of my death, subject always to the provisions of any law or government regulations. In the absence of a new beneficiary designation made by me and duly filed with the administrator under this plan, this beneficiary designation shall be valid.

I understand that I have the right to access the personal information in my file, and if necessary, correct any inaccurate information.

Member signature		Date dd/mm/yyyy	

I confirm this member is actively working and has met the eligibility requirements.

Employer signature		Date dd/mm/yyyy	

Return completed form to
ELCIC Group Services Inc. A1 – 844 McLeod Ave. Winnipeg, MB R2G 2T7
T: 204-984-9181 F: 204-984-9179 Toll Free: 1-877-ELCICGS (352-4247) Email: admin@elcicgsi.ca Website: www.elcicgsi.ca
We recognize and respect every individual's right to privacy. Refer to the GSI website for our complete Privacy Policy.