Clear Form

the benefits trust

selectflex benefits

EMPLOYEE BENEFITS ENROLLMENT FORM

Part A: Employee to complete in ink

Personal Information

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

Last Name: _____ First Name: _____

Address: _____ Apt. # _____

City: _____ Province: _____ Postal Code: _____

Date of Birth: (Month) _____ (Day) _____ (Year) _____ S.I.N. : _____ - _____ - _____

Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Common Law Length of C/L Relationship: _____

Dependant Information

Please list all dependants. Dependants include your spouse, common-law spouse (relationship of at least one year), and/or children. Eligible dependant children are under age 21. Eligible overage dependant children are over age 21, under age 26 and attending school full time; or mentally or physically handicapped children who depend fully upon you for support and maintenance and are over age 21. Complete an "**Overage Dependant**" form if applicable.

	Last Name	First Name		Date of Birth (Month)	(Day)	(Year)
Spouse	_____	_____	☐ M ☐ F	_____	_____	_____
	Child's Last Name	**First Name**		**(Month)**	**(Day)**	**(Year)**
1.	_____	_____	☐ M ☐ F	_____	_____	_____
2.	_____	_____	☐ M ☐ F	_____	_____	_____
3.	_____	_____	☐ M ☐ F	_____	_____	_____
4.	_____	_____	☐ M ☐ F	_____	_____	_____

Co-ordination of Benefits

Does your **spouse** have benefits coverage through his/her employer's plan? ☐ No ☐ Single ☐ Family

Provide the name of your Spouse's Employer and Insurance Company below:

Spouse's Employer: _____ Insurance Company: _____

Selection of Coverage (Mandatory Health Care)

Please indicate Single coverage (for yourself only), Family coverage (for yourself and your dependants), or Waived (no coverage for yourself and no coverage for your dependants).

☐ Single ☐ Family ☐ Waived

You may only Waive coverage if you are covered for similar benefits under your spouse's plan. When Dental Care benefits are included in your coverage, this selection will apply to Dental Care benefits also.

Revocable Beneficiary Designation

If your beneficiary is a child under age 18, complete a "**Declaration Appointing Trustee**" form.

Beneficiary's Last Name	First Name	Relationship (e.g. spouse, child)	(If designating a child) Age
_____	_____	_____	_____

For Quebec residents: the appointment of a spouse as Beneficiary is considered "IRREVOCABLE" unless the word "REVOCABLE" is written after the spouse's name.

Employee Authorization

I hereby apply for the benefits for which I am or may become eligible, subject to any waiver indicated, under the Select Flex Benefits Plan administered by The Benefits Trust. On behalf of myself and my dependents, I authorize The Benefits Trust (including its affiliates and/or insurance partners) to exchange the information detailed in this Enrollment and any other benefit related information contained in files regarding me or my dependents, now or in the future, for the purposes of administration and/or management of the benefits plan administered by The Benefits Trust.

Employee Signature: _____ Date: (Month) _____ (Day) _____ (Year) _____

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EMPLOYEE BENEFITS ENROLLMENT FORM

Part B: Employer to complete in ink

Instructions to Employer:

1. This application **must** be completed in **INK.**
2. Before submitting this application to The Benefits Trust please ensure that it has been completed fully. An incomplete form will delay the employee's enrollment in the plan.
3. This application **must be** received by The Benefits Trust **within 31 days** of the employee becoming eligible to join the benefits plan. If the application is received after such time, the applicant will be treated as a **LATE ENTRANT** and may be required to submit evidence of insurability to be eligible for benefits coverage.

Employer Information

Name of Employer _____ Policy Number _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Employee Coverage and Eligibility Information

Employee's Occupation _____ Benefit Class _____ Annual HCSA Amount _____ Earnings _____

☐ Annually
☐ Monthly
☐ Weekly
☐ Hourly

Date Employed on a Full-time Basis: (Month) _____ (Day) _____ (Year) _____

Date Coverage To Begin: (Month) _____ (Day) _____ (Year) _____

NOTE: Coverage begins three months after full time employment.

Employer Comments Please note any exceptions or other comments (e.g. waive three month waiting period requirement in full)

Employer Authorization

Name of Representative: _____ (please print clearly)

Authorized Signature: _____ Date: (Month) _____ (Day) _____ (Year) _____

FOR INTERNAL USE ONLY

The Select Flex Benefits Plan is administered by:

The Benefits Trust Inc.
3800 Steeles Avenue West, Suite 102W, Toronto, Ontario L4L 4G9

Phone: 416-498-7723 or 905-264-8990 Fax: 905-264-1123
Toll Free: 1-800-487-2993