Enrollment/Change Form

Section 1 Employee Information

Please print clearly

Name of Employer			Client No.
Employer's Address			Class/Sort Group
Name of Employee			Identification No.
Employee's Address			
Date of Birth (yyyy/mm/dd)	❑ Male ❑ Female	Coverage Option ❑ Single ❑ Family	Occupation
Date of Employment (yyyy/mm/dd)	❑ Full Time ❑ Part Time	Annual Earnings	Number of Hours Worked per Week

Section 2 Dependent Information

Name of Spouse (If common law, please provide date cohabitation commenced.)	❑ Male ❑ Female	Date of Birth (yyyy/mm/dd)	Relationship
Request to Co-ordinate or Waive Benefits Co-ordinate ❑ Health ❑ Dental Waive ❑ Health ❑ Dental	Name of Spouse's Insurance Provider		Policy No.
Name of Dependent	❑ Male ❑ Female	Date of Birth (yyyy/mm/dd)	Relationship
Name of Dependent	❑ Male ❑ Female	Date of Birth (yyyy/mm/dd)	Relationship

Section 3 Change Request

Nature of Change	❑ Termination ❑ Layoff	❑ Reinstatement ❑ Beneficiary	❑ Salary: $ ❑ Dependent Status*	❑ Other:	Effective Date
*Dependent Status Change	❑ Single ❑ Family	❑ Marriage ❑ Birth	❑ Common Law Status (please provide date cohabitation commenced) ❑ Other:		

Section 4 Beneficiary Designation

1. Unless otherwise stipulated and unless prohibited by law, the designation of any beneficiary is revocable.
2. This designation, as authorized by the employee signature and the date below, supercedes any prior beneficiary designation.
3. If any named beneficiary is a minor (under the age of majority) you may want to name a trustee to receive the proceeds in trust for the minor until he/she attains the age of majority. Any appointed trustee will remain valid once the beneficiary reaches the age of majority unless a trustee expiration date is provided below.
4. If more than one beneficiary is designated, in the absence of an employee assigned percentage, the benefit will be split equally among each named beneficiary.

Beneficiary's Full Name	Relationship	Percentage of Benefit Assigned	Trustee Assigned ❑ Yes ❑ No
Beneficiary's Full Name	Relationship	Percentage of Benefit Assigned	Trustee Assigned ❑ Yes ❑ No
Trustee Assignment (recommended if beneficiary is under the age of majority)			Expiry Date of Trustee Appointment

Section 5 Authorization

Employee

I hereby apply to enroll in the group benefits program for which I am, or may become, eligible and I agree to be bound by these terms and conditions. I understand that my claims may be denied and/or benefits terminated if I provide false, incomplete or misleading information. I understand that on the date my insurance becomes effective that I must be actively at work.

I authorize ENCON and its insurers to collect, use, disclose, maintain and exchange my information with the understanding that my information will be used solely for the purposes of administration, management of my group benefits plan and adjudication of claims. Access to my information shall be limited to ENCON, its insurers, service providers or persons authorized access by law. This consent shall continue so long as myself and my dependents are covered by, or are claiming benefits under the present group contract or any modification, renewal or reinstatement thereof. I authorize the use of my Social Insurance Number as my employee number for the purpose of identification under this group policy. I acknowledge that specific details of ENCON's Privacy Policy can be found at www.encon.ca.

Please sign here Signature Date (yyyy/mm/dd)

Employer

The undersigned, on behalf of the above-noted company, hereby certifies that, to the extent that available records and information permit, the statements on this form are true and complete and no material information has been omitted or withheld.

Please sign here Signature Date (yyyy/mm/dd)