KECHNIE BENEFITS

Group Benefits
Employee Enrollment Application

Please send completed forms to:

Kechnie Benefits
262 Queen Street South
Kitchener ON N2G 1W3

Section A-Plan sponsor information

Employer Name	Firm Number	Group Number	Class	Waive Waiting Period? *See below ○ NO ○ YES
Date Of Full Time Employment (dd/mmm/yyyy)	Regular Hours/Week	Annual Earnings $	Employee's Title/Occupation	
Plan Administrator/Authorized Signature			Date (dd/mmm/yyyy)	

**The waiting period can only be waived if our office receives the application within 2 weeks of the date of hire. If applicable, the employee's effective date of coverage will be backdated to the date of hire.*

Section B- Plan member information

○ Mr. ○ Mrs. ○ Miss. ○ Ms.	Last Name	First Name	Middle Name(s)	Date Of Birth (dd/mmm/yyyy)
○ Single ○ Married ○ Widowed ○ Separated ○ Divorced ○ Common Law Martial Status Effective Date: _____	Sex ○ Male ○ Female	Language of Preference ○ English ○ French	Home Phone Number ( )	
Address (number,street,apt. number)	City	Province	Postal Code	
Email Address (optional)				

Section C- Applying for Health & Dental benefits

HEALTH	DENTAL	
		Single Coverage (myself only)
		Family Coverage (myself and my spouse/children)
		None, because my spouse has coverage through their employer **(Please complete section D)**

Note: You may refuse health & dental benefits for yourself and dependent(s) **ONLY** if you are covered for similar benefits under your spouses plan. You may apply at a later date for benefits you have refused. Certain conditions will apply. Please see your Plan Administrator for details.

Section D- Spouses Health & Dental Coverage – Coordination of Benefits

(If your spouse does **not** have his or her **own** coverage this section does not apply)

Health	Dental	
		Your Spouse **ONLY** (single coverage)
		Your spouse, you and your children (family coverage)

Name of Employer: _____
Contact Information: _____
Name of Carrier: _____
Effective date: _____

Section E- Family Information

Dependent's Full Name	Date of Birth (dd/mmm/yyyy)	Sex (M or F)	Disabled Dependent? (Yes or No)	Full-Time Student? (Yes or No) If yes, name accredited institution
Spouse				
Child				
Child				
Child				
Child				

Section F- Beneficiary Designation

I hereby designate the following revocable beneficiary to any Life Insurance benefits payable as a result of my participation in the plan. A trustee must be assigned to beneficiaries less than 18 years of age. If a beneficiary is not assigned, "Estate" will be assumed.

Beneficiary Codes:

1 – Primary Beneficiary (*person or persons who will receive the proceeds of insurance under the policy upon the death of the insured person)*

2 – Contingent Beneficiary (*person or persons who will receive the proceeds of insurance under the policy upon the death of the insured person and the primary beneficiary)*

3 – Trustee (*person or persons who is the trustee of a beneficiary or contingent beneficiary under the age of 18)*

Name (First, Last)	Contact information (if different than the member)	Relationship to Member	Beneficiary Code	Percentage
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For Quebec residents only

If beneficiary is chosen as irrevocable, his/her consent is required to change it. Include a signed and dated consent with this form. You are responsible for ensuring the validity of your designation.

In Quebec, the designation of your spouse as beneficiary is irrevocable unless otherwise specified.

If spouse is beneficiary, designation is:

◯ Revocable ◯ Irrevocable

Section G- Plan Member Signature

I designate the person(s) named above under Beneficiary Designation as my beneficiary. I certify that the information in this form is true and complete, to the best of my knowledge. If applying for benefits for my dependents, I am authorized to release information concerning my spouse and my dependents, for the purposes of determining their eligibility for benefits. If applicable, I authorize my plan sponsor to make deductions from my pay for my group benefits.

Plan Member Signature	Date Signed (dd/mmm/yyyy)