

**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 <input type="radio"/> NO <input type="radio"/> 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**

<input type="radio"/> Mr. <input type="radio"/> Mrs. <input type="radio"/> Miss. <input type="radio"/> Ms.	Last Name	First Name	Middle Name(s)	Date Of Birth (dd/mmm/yyyy)
<input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Widowed <input type="radio"/> Separated <input type="radio"/> Divorced <input type="radio"/> Common Law Martial Status Effective Date: _____		Sex <input type="radio"/> Male <input type="radio"/> Female	Language of Preference <input type="radio"/> English <input type="radio"/> 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	
<input type="checkbox"/>	<input type="checkbox"/>	Single Coverage (myself only)
<input type="checkbox"/>	<input type="checkbox"/>	Family Coverage (myself and my spouse/children)
<input type="checkbox"/>	<input type="checkbox"/>	<b>None</b> , because my spouse has coverage through their employer <b>(Please complete section D)</b>

**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	
<input type="checkbox"/>	<input type="checkbox"/>	Your Spouse <b>ONLY</b> (single coverage)
<input type="checkbox"/>	<input type="checkbox"/>	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.*

<p>In Quebec, the designation of your spouse as beneficiary is irrevocable unless otherwise specified.</p> <p>If spouse is beneficiary, designation is:</p> <p><input type="radio"/> Revocable    <input type="radio"/> Irrevocable</p>
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**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)
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