

Enrolment Form For Kechnie Benefits

Company Name: _____

First Time Enrolling On This Plan? Yes No

Employee Information:

Class: **A B C**
(Please circle One if Applicable)

Full Name: _____

SIN #: _____

Address: _____

Date of Birth: _____

Employment Start Date (m/d/y): _____

City: _____

Benefits Effective Date (m/d/y): _____

Province: _____ Postal Code: _____

Phone Number: _____

Dependent Information:

Do you have a spouse? Yes No

Full Name	Date of Birth (M/D/Y)
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Co-ordination of Benefits:

What Health Care coverage does your spouse have? Single / Family / None

What Dental coverage does your spouse have? Single / Family / None

Please provide information about your spouse's plan:

Spouse's Employer:
Name of Insurer:

Do you have a dependent children? Yes No

Full Name	Date of Birth (M/D/Y)	Was This Child Handicapped Before Age 21?	Are they Attending School Full-Time? If Yes - What College/University?

* (if the dependent is not a resident of Ontario, please note their province)

Coverage Requested:

Health Coverage: Single / Family / Waiver

Dental Coverage: Single / Family / Waiver

Stop Loss Information:

(If Applicable)

As part of the Health Benefits provided through my employer, I (myself and my dependents) wish to be insured under the Group Insurance Stop Loss Program (Master contract through Royal sun & Alliance). For consideration under this policy, I must answer the following question:

Have you, or any of your dependents, on an individual basis, incurred more than \$ _____ in Health Benefits in the last 12 month period?		
No	Yes →	Approx. Amount Claimed: \$ _____ Name of Claimant: _____

I hereby authorize the release of medical claims information solely for the purposes of determining eligibility and validating claims under this policy. I understand that this information can be forwarded to any other third party and will be used for determining eligibility and validating the claim according to the terms of the Group Insurance Stop Loss Policy. The answers on the application are true and complete to the best of my knowledge. I understand any material misinterpretation shall render the coverage void. This form constitutes an application for Health Benefits and authorizes the deduction from my pay of any contributions I must make towards the cost of these benefits.

Employee Signature

Return By Mail or Fax:



262 Queen Street South
Kitchener, ON N2G 1W3
Fax: 519-571-2424

Date