Capital Health

# Group Insurance Enrollment Form
# for NSGEU, Confidential Excluded, Management

| Name of Policyholder<br>**Capital District Health Authority** | | | Employee ID | | Effective Date of New Coverage (to be entered by administrator) |
|---|---|---|---|---|---|
| Last Name | First Name | Initial(s) | | | Social Insurance Number |
| Birth Date: Day / Month / Year | | | Sex (M/F) | Telephone# Home<br>Work | _____ |
| Address Street & No. | | | | | |
| City or Town | | | Province | | Postal Code |

**Marital Status - check one and please indicate dd/mm/yy**

| Married ☐ | Common-law spouse ☐ (Date of Cohabitation) | Single ☐ | Widow(er) ☐ | Divorced ☐ | Separated ☐ |
|---|---|---|---|---|---|
| | | | | | |

**Coverage Required:** **Health** Single__ Family__ **Dental** Single__ Family__ **Dependent Life (optional)** __

## Coverage Waiver Information

***Due to my health/dental coverage under another plan, I elect not to participate in the CDHA plan: Health__ Dental__**
*Proof of coverage is required, i.e. a letter from the administrator/insurer confirming: *Name of insurer, Policy number Coverage date, Type of coverage.* ***Coverage will not be waived until this letter is received.***

## Dependent Information - Complete if applying for Dependent Life or Family Health or Family Dental

| | Last name, First Name and Initials | Sex (M/F) | Date of birth (d/m/y) | Dependent Status** (indicate relationship for child of not natural or adopted) |
|---|---|---|---|---|
| Spouse | | | | |
| Child | | | | |
| Child | | | | |
| Child | | | | |
| Child | | | | |

**Child, S-Student (college/university), Disabled

## Beneficiary Designation for Basic Life and Basic Accidental Death and Dismemberment Insurance

| Last Name and Full First Name | Percentage | Relationship |
|---|---|---|
| | | |
| | | |
| | | |

Name of Trustee(s) if Beneficiary is under age 18: _____

## Declaration

I am applying for insurance coverage in accordance with the provisions and conditions of the Group Insurance Contract issued at the policyholder's request. I authorize the policyholder to deduct from my earnings any required contribution for the insurance to which I am or may be entitled. I authorize the use of my Social Insurance Number for group insurance identification purposes and as required by law, for income tax reporting.

| Signature of Employee | Date |
|---|---|
| Witness (Please Print) | Date |
| Witness Signature | |
| IPS Data Entry Analyst | Date |

**Please ensure your beneficary does not act as your witness.**

**The original signed form is legally required to update your beneficiary information.**