

## DEPENDENT CRITICAL ILLNESS ENROLLMENT APPLICATION

For coverage effective September 1, 2010

APPLYING FOR: PLEASE PRINT CLEARLY

EMPLOYEE INFORMATION									
First Name	Initial Last Name								
Address	City or Town				Province		P	ostal Code	
Telephone Number	Date of Birth (DD/MM/YY)				Gender (M/F)				
For the following dependents, I wish to apply for \$10,000 Dependent Critical Illness Benefit, effective September 1, 2010.									
ELIGIBLE DEPENDENT CHILDREN									
Last name	Firs	I First name   Initial			der Date of birth F DD MM Y			Dependent Status*	
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05 -									
Indicate other dependent children on additional application form.	dicate other dependent children on additional application form.  * CH – Child; E - Student (college/university – PROOF REQUIRED); S - Disabled								
DECLARATION AND AUTHORIZATION: I hereby consent to the information provided in this form being collected, used or disclosed by Health Association Nova Scotia and/or any of its agents and service providers, including but not limited to insurers, benefits providers or administrators, benefits consultants and medical professionals, and shared between these parties for purposes of assessing eligibility for benefits to which I may be entitled, adjudicating any claims, auditing/reviewing the benefit plan as necessary for the proper and efficient design and administration of the plan, assessing, developing and administering related programs, and maintaining an effective claims management process. If applying for benefits for my spouse and/or dependents, I certify that I am authorized to release information concerning my spouse and/or dependents, for the purposes of determining their eligibility for benefits and any of the uses set out above. I authorize my employer(s) to notify Health Association Nova Scotia for purposes of initiating a claim for benefits or services that may be available to me or on my behalf under the plan.  I have verified the information on this form and declare that it is accurate and complete. I authorize the use of my social insurance number for group insurance identification purposes and as required by law for income tax reporting.									
Date Signature of Employee									
Please forward the original to your Employer (Human Resources or Benefits Department) Health Association Nova Scotia is a registered business name of Nova Scotia Association of Health Organizations.									
TO BE COMPLETED BY YOUR EMPLOYER ONLY									
Division Name	Division Number								
We hereby certify that this person is an eligible employee actively at work and performing the functions of his/her position.									
Date Signature of Employer									
Please forward original to Group Benefits Solutions, Health Association Nova Scotia, 2 Dartmouth Road, Bedford NS B4A 2K7.									

Please remember to sign this form.

If you are applying after September 1, 2010, please complete a Group Benefits Enrollment Form

Health Association Nova Scotia is a registered business name of Nova Scotia Association of Health Organizations.