STRIVE
INSURE

ENROLMENT / CHANGE FORM

Employer / Plan Section (to be completed by the plan administrator)

Company Name: _____ Division: _____ Policy No: _____

- ❑ **Enrol Employee (Plan effective date: _____)**
- ❑ **Reinstate Employee (Plan effective date: _____)**
- ❑ **Terminate Employee (Termination date : _____)**
- ❑ **Add Dependant: (Effective date: _____)**
- ❑ **Change Address**
- ❑ **Remove Dependant (Term. date: _____)**

Employee/ Participant Details (to be completed by the employee)

Last Name:_____ First Name:_____ M/F:_____

Street Address:_____

City:_____ Province:_____ Postal Code:_____

Date of Birth: (mm/dd/yyyy): _____ Daytime Phone Number: _____

Coverage Status: Single: _____ Couple: _____ Family: _____ Waived:_____

Dependant Details (to be completed by the employee)

(mm/dd/yyyy)

Spouse: Last Name:_____ First:_____ Sex:_____ DOB: _____

Child 1: Last Name:_____ First:_____ Sex:_____ DOB:_____

Child 2: Last Name:_____ First:_____ Sex:_____ DOB:_____

Child 3: Last Name:_____ First:_____ Sex:_____ DOB:_____

Child 4: Last Name:_____ First:_____ Sex:_____ DOB:_____

Please indicate the name of any disabled dependants: _____

Please indicate below, if dependants are full time students and over age 21.

Attach the registration letter, which confirms full-time enrolment .

Name of Over Age Student	College/University Attended	Enrolled From	Enrolled To

Co-ordination of Benefits / Refusal of Coverage (to be completed by the employee)

If you and/or your dependants are presently insured for Health Care and/or Dental benefits under your spouse's group policy you may co-ordinate benefits or refuse coverage under this contract by completing the appropriate areas.

My spouse has coverage through _____(insurance company) Policy no. _____

- ❑ I wish to co-ordinate coverage with my spouse's plan Health _____ Dental _____ Vision _____
- ❑ I refuse insurance on myself and dependants under: Health _____ Dental _____ Vision _____
- ❑ I refuse insurance on my dependants under: Health _____ Dental _____ Vision _____

***Please complete page 2 of this form, in its entirety.**

Stop Loss - If applicable (to be completed by the employee)

As part of the Health benefit provided through my employer (myself and my dependants) wish to be insured under the group insurance stop loss protection program.

Note: For consideration under this policy the following questions must be completed.

1. Have you or any of your dependants, on an individual basis, incurred more than 75% of the stop loss level being applied for, in health expenses, in the last twelve (12) month period?

   Yes:_____ No:_____ If yes, the approximate amount incurred $_____

   Name of applicable person (dependant):_____ DOB:_____

Electronic Funds Transfer

Branch Transit Number: _____

Bank Code: _____

Account Number: _____

Bank Name: _____

Signature (to be completed by the employee)

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 only be used for determining eligibility and validating the claim according to the terms of the Group Insurance Stop Loss Policy.

By enrolling in this plan I am authorizing the applicable insurance carriers, agents and service providers to use and exchange information collected in this form to underwrite, administer and adjudicate claims. I also authorize my plan sponsor to use this same information for benefits administration and to make any necessary payroll deductions, which may be required.

Employee / Subscriber Signature: _____

Employee / Subscriber Name (Please Print): _____

Date: _____

For Plan Administrator Use

- ❑ Information entered using Online Access.
- ❑ Keep the original form for your records.