To complete and e-sign this form online, please open it in Adobe

ICBA BENEFITS

Group Benefits
Employee Enrolment Form

For ICBA Benefits Use:
Certificate Number: _____
Effective Date (m/d/y): _____

Section 1 – Plan Sponsor / Employer complete this section

Note: Please see pages 3 & 4 for Instructions and Additional Information

Organization/Company	***Client Code***	***Policy No.***	***Billing Group No.***	***Class Code***

Employee Legal Last name	Employee Legal First Name	Check One: ○ New Application ○ Reinstatement
Date of Employment (mm/dd/yyyy)	Occupation	Regular hours worked per week

Salary _____ Per: ○ Year ○ Month ○ Week ○ Hour	Is this a ***Late Application***? ○ No ○ Yes - ***Evidence of insurability form*** is attached ○ Yes - ***Evidence of insurability form*** will follow

○ Apply plan waiting period
○ Waive waiting period (additional information may be required – contact us to find out your plan's requirements.)

Your Name and Title	Email address	Phone No.
Date signed (mm/dd/yyyy)	Signature	

Section 2 – Employee complete this section

Date of birth (mm/dd/yyyy)	***Gender*** (X denotes non-binary) ○ Male ○ Female ○ X	***Do you have a spouse?*** ○ Yes ○ No For common-law, date of cohabitation:_____ (mm/dd/yyyy)

Email address	Daytime phone number	***Do you have dependent children***: ○ Yes ○ No	
Home address (number, street, suite #)	City	Province	Postal Code

Coverage selected **Health**: ○ Single ○ Family ○ Waive* **Dental**: ○ Single ○ Family ○ Waive*

**Waive denotes coverage through spouse's plan. See additional information on page 4 - Waiving Health and/or Dental.*

Spouse Plan Information – complete if you are waiving Health/Dental coverage.

Insurance Company	Policy/Group No.	Type of coverage: ❑ Health ❑ Dental	Cardholder: ○ My spouse ○ ***Other:***	Coverage ○ Single ○ Family

Dependent Information **– complete if you have a spouse/eligible children, even if you are waiving coverage for them.**

Note: If your child is disabled, additional information is required to approve coverage beyond the plan's age limits. Contact us for more information.

❑ More than 5 children, attach list

	Legal Last Name	**Legal First Name**	**Date of Birth (mm/dd/yyyy)**	***Gender*** *(X denotes other/non-binary)*	***If over 21:***
Spouse				○ Male ○ X ○ Female	n/a
Child				○ Male ○ X ○ Female	❑ Full-time Student ❑ Disabled
Child				○ Male ○ X ○ Female	❑ Full-time Student ❑ Disabled
Child				○ Male ○ X ○ Female	❑ Full-time Student ❑ Disabled
Child				○ Male ○ X ○ Female	❑ Full-time Student ❑ Disabled
Child				○ Male ○ X ○ Female	❑ Full-time Student ❑ Disabled

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Section 3 – Employee complete this section

Beneficiary Designation for Basic Life and Basic Accidental Death insurance (please use legal names only):

Primary Beneficiary(ies)

	Name	Date of Birth (mm/dd/yyyy)	Relationship to You	*Type* Important: See note below	Percentage
1	Last name First name Initial			○ Revocable ○ Irrevocable	%
2	Last name First name Initial			○ Revocable ○ Irrevocable	%
3	Last name First name Initial			○ Revocable ○ Irrevocable	%
4	Last name First name Initial			○ Revocable ○ Irrevocable	%

If you designate a beneficiary, primary or contingent, as irrevocable, that person's consent is required if you later want to change your beneficiary. A minor child cannot give consent, therefore if you designate a minor child as irrevocable, you will not be able to change your beneficiary until the child reaches the age of majority and consents to the change.
The percentages must total 100%. If percentage is left blank, insurance will be split evenly among the beneficiary(ies). To designate more than four primary beneficiaries or more than one contingent beneficiary, complete our Beneficiary Designation form. If you do not designate a beneficiary, proceeds will be paid to your estate.

***Trustee* (Complete if any beneficiary is under the age of majority. Please indicate full legal name in appointment below)**

I appoint _____ as Trustee to receive any amount due to any beneficiary under the age of majority.

Contingent Beneficiary	Date of Birth (mm/dd/yyyy)	Relationship to you	Type Important: See note above
Last name First name Initial			○ Revocable ○ Irrevocable

Section 4 – Employee complete this section

Protecting your personal information

ICBA Benefits is committed to protecting the privacy, confidentiality, accuracy and security of your personal information. Your personal information, and the personal information of your spouse and dependents, if applicable, will be collected and used by us to determine your eligibility for group benefits coverage, to administer the group benefits plan, to assess benefits and insurance claims and for other purposes described in our Privacy Policy, which is available at icbabenefits.ca. Access to personal information is limited to authorized employees and contractors of ICBA Benefits who require it to perform their duties, to those persons that you have granted access (such as your spouse or employer) and to other persons authorized by law.

Personal information may also be shared with third parties that help us administer the group benefits plan, such as insurance companies and their reinsurers, your employer, health services providers, administrators of government benefits or other benefits programs and our technology partners, including for the purposes of verifying eligibility for specific benefits or claims, processing payments and investigating or reporting suspected or apparent fraudulent or suspicious claims behaviour.

For more information about our privacy practices and procedures, please see our Privacy Policy or contact our Privacy Officer at privacy@icbabenefits.ca.

Declaration and authorization

I hereby apply for coverage under this policy, and accept its terms and conditions. I authorize the necessary contributions to be made through payroll deductions, if applicable.

I have read, understand and agree with the section above entitled "Protecting your personal information" and hereby consent to the collection, use and disclosure of my personal information as described in this form and ICBA Benefits' Privacy Policy. If I have provided the personal information of my spouse or any dependents, I hereby confirm that I am authorized to act on their behalf.

I understand that I am responsible for the accuracy of all claims submitted on behalf of myself, my spouse and/or my dependents, and that my eligibility and/or entitlement to any or all benefits under the Plan may be suspended and/or revoked without notice in the event that I, my spouse or any dependents am found to have made fraudulent or repeated inaccurate claims under the plan. Further, I hereby authorize my employer to deduct from my payroll and remit to the plan any amounts paid to me as a result of fraudulent or inaccurate claims by myself, my spouse or my dependents.

I certify that I am covered, and my spouse and dependents (if applying for coverage) are covered by a provincial medical plan, e.g. Medical Services Plan of BC.

I certify that all of the information I have provided on this form is true, correct and complete to the best of my knowledge.

Signature:	Date Signed (mm/dd/yyyy):

Return completed form to ICBA Benefits via email (for active groups, indicate your policy number in the email subject line), or by mail. If you email the form, you are not required to send the original by mail.

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Instructions/Additional Information:

Billing Group No. – Provide only if the plan has multiple divisions or billing groups; otherwise leave blank. If applicable, the number will appear on your monthly invoice.

Class Code – Provide only if your plan includes a class number; otherwise leave blank.

Client Code – Indicate either number as it appears on your monthly invoice.

Contingent Beneficiary – If all the primary beneficiaries should die before you, proceeds will be paid to a contingent beneficiary. Should there not be any surviving beneficiaries at the time of your death, the proceeds will be paid to your estate.

Coordination of Benefits information – This information is required to establish which plan is primary and which plan is secondary for Health and Dental claims. If you are waiving coverage for yourself/your dependents, some carriers require that you provide this information as proof of other coverage.
Note: If you are applying for Health and/or Dental after having previously waived coverage, or if you are enrolled for Health and/or Dental and now want to waive coverage, complete our Amendment to Coverage Status form.

Date of employment – Indicate the date the employee began working 20 hours per week on a regular basis, not including overtime. Usually, this will be the original date of hire; however if the employee was hired on a casual basis, or on a part-time basis working less than 20 hours per week on average, enter the date employment changed to 20 hours/week. If this is a reinstatement, enter the date of rehire.

Dependent Information – complete this section if you have a spouse/eligible children, even if you are waiving coverage for them. If you are waiving Health and Dental coverage for your spouse/children, we need to know who your dependants are for two reasons: (1) in the event we later receive an enrolment request for them, and (2) your plan may include Dependent Life insurance. If you have more than 5 children, attach list with required information for the additional child(ren).

Do you have a spouse? – Indicate Yes if you are legally married or living in a common-law relationship.

Do you have dependent children? – Indicate Yes if you have a child(ren) under age 21, or a full-time student age 21-25, or a disabled child over age 21. If your child is disabled, additional information is required to approve coverage beyond the plan's age limits. Contact us for more information.

Evidence of Insurability Form – Contact us for the form.

Gender – Please indicate the gender per your government issued ID. For non-binary, indicate "X". Note: the insurance company may require a gender of male or female for underwriting purposes.

If over 21 - To be covered on your plan beyond age 21, a child must either meet Canada Revenue Agency's criteria for a full-time student, or be disabled. If your child is disabled, additional information is required to approve coverage beyond the plan's age limits. Contact us for more information.

Do not return this page to ICBA Benefits.

Group Benefits
Employee Enrolment Form

Late Application – If we receive this application more than 31 days after the employee is first eligible for coverage, it is considered late and ***evidence of insurability*** in the form of a completed health questionnaire is required. The insurance company may decline to cover the applicant(s). If the application is approved, coverage will begin as applicable, and Dental coverage will be restricted for the first 12 months of coverage. Contact us for the required form. The completed form can be scanned and emailed to us, or mailed. For confidentiality purposes, we suggest that the employee submit the form to us directly, or provide to you in a sealed envelope for mailing to us.

Other – Examples of Other plans, i.e. where the cardholder is not your spouse, include coverage you have through another employer or retiree plan. Please note, not all insurance companies will accept waivers/applications related to other coverage that is not a spouse's plan. We will let you know if your application / waiver is not accepted by the insurance company.

Reinstatement – If the employee previously had coverage under the plan and coverage terminated more than 6 months from the date of rehire, the plan waiting period will be applied to the date of rehire (unless there is written indication that the the Plan Sponsor/Employer is waiving the waiting period). If the previous coverage terminated less than 6 months from the date of rehire, coverage starts on the date of rehire. Note, both situations are subject to **late application** rules.

Trustee - Designate a trustee for any beneficiary who is younger than the age of majority in your province.

Type (Beneficiary Designation) – If you designate a beneficiary as Irrevocable, you cannot change your beneficiary designation without that person's consent. Important note: If you designate a minor child as your Irrevocable beneficiary, the child cannot consent to a change in beneficiary until they reach the age of majority. If you designate your beneficiary as Revocable, you may change your beneficiary designation at any time without restriction.

Waiving Health and/or Dental – You may waive coverage for yourself or for yourself and your dependents only if you/they are covered for Health and/or Dental benefits under another plan. If the other plan terminates, there are time limits for applying for coverage under this plan. If you apply late or while the other plan is still active, Dental coverage may be restricted for the first year, and you and/or your dependents will have to provide evidence of good health, and the insurance company may decline to cover you and/or your dependents.

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