



Reinstatement of Waived Benefits

Western Canada
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Eastern Canada
 3-55 Rideau Street, Kingston, ON K7K 2Z8
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Name of Employer:

- ▶ To use this form you must already be insured under your employer's plan. ◀
- ▶ For a new enrollment complete a Group Insurance Enrollment form. ◀

▶ Employee – Complete this section ◀

Employee Last Name		First Name			Initial			Are you covered under your Provincial Health Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dep. No.	List Dependents			Sex M/F	Birth Date			Relationship to You	If child is over plan's age limit (e.g. 19 or 21), and attending school full-time, provide name of school. If child is handicapped, state nature of disability to apply for coverage beyond plan's age limits
	Last Name	First Name	Initial		Month	Day	Year		
01	Spouse								
02	1st Child								
03	2nd Child								
04	3rd Child								
05	4th Child								

▶ I now wish to apply for my employer's Extended Health Care and/or Dental Care benefits which I previously waived: (specify requested benefits below):

For myself only Extended Health Care
 Dental Care

For myself and my dependents.... Extended Health Care
 Dental Care

Other (specify reason for application)

▶ Reason for This Application (check one and provide details)

Termination of the Other Plan
 Date of termination _____

Separation or Divorce
 Date of termination from the other plan _____

If you have children, are they still covered under the other plan?
 Yes No

If yes, please specify the details of the other plan:
 Name of Other Plan's Policy Holder/Employer:

Name of Insurance Company

Group Number _____ Identity Number _____