Group Insurance Enrollment

☐ New Employee
☐ Reinstatement

Please mail original completed form to BBD:

Western Canada
500-2755 Lougheed Highway Port Coquitlam, BC V3B 5Y9

Eastern Canada
107 – 6 Cataraqui Street Kingston, ON K7K 1Z7

Name of Employer:

▶ *PLEASE PRINT. Please submit original application only — fax copies or photocopies cannot be accepted* ◀

▶ Employee – Complete this section ◀

Employee Last Name	First Name	Initial	Are you in Canada on a Work Visa/Permit? *Copy required to enroll in plan. ☐ Yes ☐ No	Are you covered under your Provincial Health Plan? ☐ Yes ☐ No

Home Address	City	Province of Residence	Postal Code

Gender: ☐ Male ☐ Female

Birth Date: Month / Day / Year

Language Preference ☐ English ☐ French **Personal Email Address:** _____

Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Common Law* ☐ Widowed
* Date of Cohabitation _____ (*Date of Cohabitation is mandatory if Common Law)

Dep. No.	List Dependents: Last Name	First Name	Initial	Sex M/F	Birth Date: Month	Day	Year	Relationship to You	*If child is over 21 years of age 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.*
01	Spouse								
02	1st Child								
03	2nd Child								
04	3rd Child								
05	4th Child								

Partial Waiver

The Information below must be completed for partial waiver due to coverage under another plan
I elect to waive the benefits checked below because comparable coverage is provided to me and/or my dependents under another group plan:

Do you have duplicate coverage under another Extended Health or Dental plan (e.g. your spouse's group plan)? If yes, provide details below:

_____ _____ _____ ☐ EHC ☐ Dental
Name of Insurance Company | Group Number | ID Number

▶ **For myself and my dependents** ..... ☐ Extended Health Care ☐ Dental Care **OR** ▶ **For my dependents only** ..... ☐ Extended Health Care ☐ Dental Care

Is this your Spouse's group plan ☐ Yes ☐ No **(If No, provide Details)** _____

Beneficiary Designation

Beneficiary Designation (use full legal name – e.g. Mary Jane Doe, not Mrs. John Doe)
I designate as revocable beneficiary in the event of my death:

_____ _____ _____%
_____ _____ _____%
Full Legal Name | Relationship | Share of Proceeds

Trustee Designation (complete if beneficiary is under age 18)
I appoint as revocable Trustee to receive any amount which may be due my beneficiary, while such beneficiary is a minor:

_____
Full Legal Name

I agree to the conditions of the contract(s) between my employer and the insurer(s) and authorize my employer to deduct required contributions from my earnings. On behalf of myself and my dependents I authorize BBD Inc. and all insurers to exchange the information detailed in this application, and any other benefit related information contained in files regarding me or my dependents, either now or in the future, for the purposes of administration and/or management of the group insurance policies issued by the insurers, and to discuss conversion options upon termination from this plan. I understand that this original document and all other original documents pertaining to me and my dependents are the property of BBD Inc. and will be permanently retained by BBD Inc. as required by the insurers. I confirm that the information I have provided is true and complete.

X _____
Signature of Employee **Date**

▶ Employer – Complete this section ◀

Employee's Earnings	Hours Per Week	Payroll Number (optional)
$ _____ ☐ Annually ☐ Monthly ☐ Weekly ☐ Hourly		Department Number / Employee Number
Employee's Occupation	**Class Code**	

Date of Employment (New Employee)			Date of Rehire (Reinstatement)			Effective Date (for administrator use only)		
Month	Day	Year	Month	Day	Year	Month	Day	Year

I confirm that this employee is eligible to apply for coverage and that the information I have provided is true and complete.

X _____
Authorized Signature of Employer **Date**