# Reinstatement of Waived Benefits

**Western Canada**
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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? ☐ Yes ☐ No |
|---|---|---|---|
| | | | |

| Dep. No. | List Dependents: Last Name | First Name | Initial | Sex M/F | Birth Date: Month | Day | Year | 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. |
|---|---|---|---|---|---|---|---|---|---|
| 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 __________

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