Pacific Employee Benefits Ltd.
PO Box 3249, 3756 First Avenue, Smithers,BC V0J 2N0
Telephone: (250) 847-2883 Toll-free in BC: 1- 877-822-4209

Employee Enrolment Form

_____ New Employee _____ Reinstatement

To be completed by Employer		
Company/ Group Policy Name		Group Policy Number
Date of Hire (mm/dd/yy)	Does waiting period Apply?	Effective Date of Coverage (mm/dd/yy)
Class / Division		Signature of Administrative Contact

Employee Details (to be Completed by Employee)		
Last Name	First Name	Gender Male ____ Female ___
Date of Birth (mm/dd/yy)	Active Provincial Health Care Coverage? Yes_____ No_____	First Nation Information (if Applicable) Status___ Non-Status____
Marital Status Single____ Legally separated_____ Married_____ Divorced_____ Widowed_____ Common-law_____		
Required coverage level Single ____ Family____ Waived*____	Email** (required for EFT)	
Mailing Address		Telephone number
City, Province		Postal Code

Dependent Details		
Spouse name (Last/First/Middle)	Birth Date(mm/dd/yy)	Sex Male____ Female____ First Nation Information Status___ Non-Status___
Child Name (Last/First/Middle)	Birth Date(mm/dd/yy)	Sex Male ____ Female____ First Nation Information Status___ Non-Status___
Child Name (Last/First/Middle)	Birth Date(mm/dd/yy)	Sex Male___ Female____ First Nation Information Status___ Non-Status___
Child Name (Last/First/Middle)	Birth Date(mm/dd/yy)	Sex Male___ Female____ First Nation Information Status___ Non-Status___
Child Name (Last/First/Middle)	Birth Date(mm/dd/yy)	Sex Male___ Female____ First Nation Information Status___ Non-Status___

If a dependent over the age of 21 is a full time student, please be advised that you will need to provide proof of enrolment for the over age dependent.

Co-ordination of Benefits / Refusal of Coverage

If you and/or your dependents 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 below.

***You may only waive health or dental coverage if you are covered through your spouse's plan.**

My spouse has coverage through	Policy number	I wish to co-ordinate coverage with my spouse's plan Yes ____ No____
I refuse insurance on myself and dependents under:		Health _____ Dental_____
I refuse insurance on my dependents under:		Health_____ Dental_____

Banking Details for Electronic Funds Transfer (EFT)

I would like electronic deposit of health and dental claim payments into my bank account: Yes____ No____

If yes, please attach a void cheque and ensure that your email is included on page 1.

Failure to provide an email will result in our inability to process the EFT portion of your application.

Please attach a void cheque, direct deposit form or a bank verification statement. Cheques must be personalized with your name, or signed and stamped by a bank representative.

Member's Authorization

Authorization, Declarations and Signature:

I authorize Pacific Employee Benefits, its insurers, their reinsurers, service providers, and my health care providers to exchange information when necessary to determine eligibility, underwrite, adjudicate, administer the plan, and deposit claim payments. This also applies to the collection, use, and disclosure of personal information regarding my spouse and dependents, if applicable, and confirms that I am authorized to act on their behalf.

I also authorize my plan sponsor to use the information collected in this form for benefits administration, and to deduct and remit any necessary payroll deductions which may be required. I declare the information above is accurate and true.

Plan member signature: X	Date: