GROUP BENEFITS ENROLLMENT FORM

Please read through this form carefully and complete all relevant sections.

Please select your preferences for the duration of the academic year and submit to enrol@canben.com by the first date of the semester. IF YOU ARE INCLUDING POST-DATED CHEQUES, please send this form with cheques via regular mail to:

2300 Yonge Street, Suite 3000, P.O. Box 2426, Toronto ON M4P 1E4

SECTION I: PERSONAL INFORMATION

Your Last Name	**Your First Name**	**Employee Number/ID**	**Gender**	**Date of Birth** (yyyy/mm/dd)

Your Address (Street Number and Name)	**City**	**Province**	**Postal Code**

Phone Number:	**Please indicate your language of preference: English ☐ French ☐**

Marital Status	Single	Married	Separated	Divorced	Common-Law	Widowed	If common-law, provide date cohabitation commenced (yyyy/mm/dd):

SECTION II: ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE (Optional)

I would like to enroll for AD&D:

	SINGLE	FAMILY
$100,000	☐ $48.00/semester	☐ $62.40/semester
$200,000	☐ $96.00/semester	☐ $124.80/semester
$300,000	☐ $144.00/semester	☐ $187.20/semester

Please attach a void cheque and sign Page 3.

AD&D will remain in force until age 70 as long as premiums are paid.

SECTION III: COVERAGE PREFERENCES & CONTRACT STATUS

Academic Year: September 1, 2024 to August 31, 2025

What coverage do you want? (Single enrollment automatic if teaching. Only enroll if not teaching)	Single	Couple	Family
For what Semester(s) would you like coverage?	Fall	Winter	Summer
For what semesters will you have a teaching contract?	Fall	Winter	Summer

PLEASE CONTINUE TO NEXT PAGE

SECTION IV: COORDINATION OF BENEFITS

Please complete the section below if you already have Health and Dental coverage with another Plan but want to use this Benefit Plan as well and "coordinate your benefits" to increase your coverage. Should your other insurer be through your primary/full-time employer, this Plan will be your secondary payer and will reimburse any eligible unpaid remainder left from your first Plan. In the case that your other coverage is through your spouse's Plan, this Benefit Plan would be your first payer.

Other Coverage Information:	**Health:**		**Dental:**	
Do you have coverage with another insurer?	Yes	No	Yes	No
If yes, is this coverage from your other Employer? (Leave blank if not applicable).	Yes	No	Yes	No
Does your spouse have coverage with another insurer?	Yes	No	Yes	No
If yes, what level of coverage is provided?	Single	Family	Single	Family

Name of Insurance Company:		Policy/Group Number:	

SECTION V: PAYMENT PREFERENCES

Members have the option to pay via payroll deduction OR by post-dated cheque (1 cheque per semester) OR automatic withdrawal (please submit a void cheque with your Enrollment Form) OR a combination of these. Premiums for Ontario (Quebec) are:

Coverage	**IF YOU HAVE A CONTRACT: Premium Per Pay Deduction**	**IF YOU DO NOT HAVE A CONTRACT: Premium Per Semester**
Single	$27 ($31)	$890 ($933)
Couple	$117 ($132)	$1,610 ($1,801)
Family	$180 ($202)	$2,106 ($2,361)

Please note that if you choose to pay via payroll deduction it must be DURING or PRIOR to the semester you are paying for. For example, if you have a Fall contract and want full year benefits your options are:

(1) Payroll deductions in Fall semester for full academic year coverage; OR
(2) Payroll deductions in Fall semester for Fall only coverage + 2 post-dated cheques (dated Jan 1, 2025 and May 1, 2025); OR
(3) Payroll deductions in Fall semester for Fall only coverage + automatic bank withdrawal (attach VOID cheque with your application)

Please make cheques out to "CUPE LOCAL 4600-2 BENEFITS TRUST FUND"

How would you like to pay for your benefit premiums for the semesters:

Payroll deduction only ☐ Post- dated cheques only (enclosed) ☐

Combination of payroll deduction + cheques/automatic withdrawal ☐ Automatic withdrawal (attach VOID cheque) ☐

Automatic withdrawals are made on the last business day of the first month of the Semester.

PLEASE SIGN THE LAST PAGE

SECTION VI: DEPENDENT INFORMATION

Please complete the section below if you have selected Couple or Family Coverage.

Dependent Information					
	Last Name (if different than employee)	First Name	Date of Birth (yyyy/mm/dd)	Gender	If child is over 21, indicate if disabled or if a full time student. If in school, provide name of school below and attach proof of enrolment.
Spouse					
Child					
Child					
Child					
Child					

Plan Member/Employee Authorization

I hereby apply for group benefits coverage and authorize the deduction from my pay (if applicable) and remittance to Canadian Benefits Consulting Group any contributions required under the group benefits plan. I hereby authorize my employer, group plan administrator, the insurance company or their agents, or any other person or organization to release and exchange any and all information necessary for the purpose of determination of eligibility for benefits and administration of the group benefits plan. I confirm I am authorized to act on behalf of my spouse and/or dependants for such purposes.

I declare that the information provided is true, complete and accurate. Any copy of this authorization shall be valid as the original.

Plan Member/Employee's Signature: _____ **Date signed:** _____

Sign here

To ensure that coverage is kept up to date for you and your dependents, it is vital that you advise your Plan Administrator of any changes such as change of name, marital status or dependents status, or reinstatement of benefits previously waived. Changes reported more than 30 days after the date of change may require evidence of insurability.

Canadian Benefits Consulting Group cannot accept any unsigned forms.

Questions? Please contact us at (416) 488-7755, toll free at 1-800-268-0285 or at enrol@canben.com

Canadian Benefits Consulting Group

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