UHA United Health Associates Group Insurance Plan®

Group Benefit Enrolment Form

ADMINPLEX RESOURCE SERVICES INC.

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705.725.7009 / 1.800.565.2467

Purpose of Group Enrolment Form
The purpose of the group enrolment form for group insurance is to provide necessary information to obtain coverage and written confirmation that you wish to obtain coverage under the policyholder.

All sections must be completed.
Incomplete forms will be returned.
Please Print in Ink.

Employee Name	Last:			First:							
Residence	Street:		Apt #		City:		Prov:		Postal Code:		
Date of Birth (MM/DD/YY)		Language Preference	☐	English	☐	French	Gender	☐	Male	☐	Female
E-Mail Address							Phone No.				

Marital Status

☐ Single ☐ Separated
☐ Married ☐ Divorced
☐ Common Law ☐ Widowed

Required Coverage	Health	Dental
My Self Only	☐	☐
My Self & Dependents	☐	☐
Waived*	☐	☐

*If your spouse has other coverage and you wish to waive Extended Health and Dental, the following information is required:

Name of Insuring Company _____ Policy # _____

When enrolling for family benefits, coverage for dependents will only be provided if the information below is complete:

Dependent Name First and Last (Please Print Clearly)	Gender M or F	Relationship to Insured	Date of Birth MM/DD/YY	✓ Below if There is Other Coverage Health	Dental	If Dependent Child is Over the Age of 21 are They a Full-Time Student? Yes	No
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐

~ Beneficiary Designation ~

Unless otherwise designated, the beneficiary is "Revocable". If no beneficiary is designated, the beneficiary will be the Estate. If naming a minor as a Beneficiary, please appoint one in the section below. Without completion of this section, the insurer may hold proceeds until the minor reaches age of majority. For Province of Quebec Residents, the appointment of a spouse as beneficiary is considered "Irrevocable" unless the wording "Revocable" is actually selected after the spouse's name. If you are a resident of Quebec please indicate Revocable or Irrevocable.

Full First and Last Name of Beneficiary (ies)	Percentage	Relationship to Insured	Revocable	Irrevocable
	%		☐	☐
	%		☐	☐
	%		☐	☐

I appoint _____ as **Trustee** to receive any payment payable to a minor beneficiary under this policy. The trustee shall discharge the Insurer for the amount paid. I authorize the "Trustee" to spend all or part of the amount, or interest earned on it, for the support or education of the minor.

Signature of Participant _____ Signature of Witness _____ Date Signed (MM/DD/YYYY) _____

~ Declaration and Authorization for the Collection and Communication of Personal Information to Third Parties ~

I authorize Adminplex Resource Services Inc. and affiliated companies, strictly for the purposes of providing group insurance to collect from me and my employer only information deemed necessary to provide group insurance and communicate the said information only to organizations deemed necessary to provide and process my group insurance. I am applying for insurance coverage in accordance with the provisions and conditions of the Group Insurance Contract issued at the Policyholder's request. I authorize the policyholder to deduct from my earnings (if applicable) the required contribution for the insurance to which I am or may be entitled

_____ _____
***** Signature of Participant ***** ***** Date Signed (MM/DD/YYYY) *****

To Be Completed by Plan Administrator

Policy No.		Policy Name							
Payroll No.		Class				Department Code			
Salary		Salary Basis	☐	Annual	☐	Bi-Weekly	☐	Weekly	☐ Monthly ☐ Hourly
No. of Hours Worked per Week		Occupation							
Date of Hire (MM/DD/YY)		Date of Full-Time Employment (MM/DD/YY)				Date Waiting Period Completed (MM/DD/YY)			

_____ _____
***** Signature of Plan Administrator ***** ***** Date Signed (MM/DD/YY) *****