

Application for Employee Benefits



EMPLOYER INFORMATION

Merchant Name		Store No.	
Merchant Address		City	Province
Postal Code	% Employer Participation	Effective Date* (yy/mm/dd)	

**1st day of the month following the eligibility period or as per the union convention.*

IMPORTANT: The participant must be active at work upon the Effective Date, otherwise please advise us immediately.

EMPLOYEE INFORMATION

Employee Name		Date of Birth (yy/mm/dd)	Employee Number	
Address		City	Province	Postal Code
Hire date (yy/mm/dd)	Number of Hours Worked	Date of Full Time Hire (yy/mm/dd)	Date of Part Time Hire (yy/mm/dd)	
Eligible Period* <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> Union Convention		E-mail Address		

**The application must be submitted within 31 days following the Eligible Period.*

Gross Earnings:	<input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Hourly	Premium:	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
Occupation:	<input type="checkbox"/> Owner <input type="checkbox"/> Manager <input type="checkbox"/> Union Employee <input type="checkbox"/> Non Union Employee <input type="checkbox"/> Director		
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> English <input type="checkbox"/> French	Province of Residence	
Merchant Signature	Signed at: (city)	Date (yy/mm/dd)	

EMPLOYEE DECLARATION – COVERAGE INFORMATION

Extended Health Care	Dental Care
<input type="checkbox"/> Myself Only <input type="checkbox"/> Myself and Dependent <input type="checkbox"/> None, my spouse has coverage (complete below)	<input type="checkbox"/> Myself Only <input type="checkbox"/> Myself and Dependent <input type="checkbox"/> None, my spouse has coverage (complete below)
Are you: <input type="checkbox"/> Legally Married <input type="checkbox"/> Common-Law Spouse	If Common-Law Spouse, Cohabitation Date (yy/mm/dd)

For Québec resident 65 years old and over: Are you an active participant of the RAMQ (Régie de l'assurance maladie du Québec)? Yes No

NOTE: You may opt out of benefits for yourself and your dependents only if you are covered for similar benefits under your spouse's plan. You may apply at a later date for benefits you have refused. Certain conditions may apply.

COVERAGE INFORMATION

Spouse's Health Coverage	Spouse's Dental Coverage
Does your spouse have coverage for Extended Health Care? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does your spouse have coverage for Dental Care? <input type="checkbox"/> Yes <input type="checkbox"/> No
*If yes, please complete below:	*If yes, please complete below:
Policy Number	Policy Number
Insurance Company	Insurance Company
Effective Date of Coverage (yy/mm/dd)	Effective Date of Coverage (yy/mm/dd)
*You must submit proof of coverage.	*You must submit proof of coverage.
Your spouse's program covers:	Your spouse's program covers:
<input type="checkbox"/> Your spouse only <input type="checkbox"/> Your spouse and children <input type="checkbox"/> Your spouse, yourself and children <input type="checkbox"/> Your spouse and yourself	<input type="checkbox"/> Your spouse only <input type="checkbox"/> Your spouse and children <input type="checkbox"/> Your spouse, yourself and children <input type="checkbox"/> Your spouse and yourself

Please complete reverse side.

FAMILY INFORMATION - Please complete this section with spouse & dependent children regardless of coverage selected.

Name of Dependent(s)	Birth Date (yy/mm/dd)	Gender	Relationship to Employee	Disabled	Full Time Student*
		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Please submit an HED Courtier en Assurance Inc. Over-age Dependent Coverage form for any child over age 21 who is a FULL-TIME STUDENT. Incomplete or missing information may result in a dependent life claim being denied.*

BENEFICIARY DESIGNATION

**If no beneficiary is assigned then "ESTATE" will be assumed.
If benefits are assigned to minor children, a trustee must be appointed to act on their behalf.**

Beneficiary Name (first, initial, last)	Birth Date (yy/mm/dd)	% Allocated	Relationship to Employee

**The Insurer merely reports designations or changes beneficiaries and declines any responsibility as to their validity.
This designation applies to all life benefits under the policy.**

In Québec, the designation of your spouse as beneficiary is irrevocable unless otherwise specified. **Revocable** **Irrevocable**
You will need the beneficiary signature to change an irrevocable designation.

EMPLOYEE AUTHORIZATION

All Statements, representations and answers made in this application are consideration for and a basis of the insurance herein requested and whether written or printed are declared to be true, full and complete.

At HED Courtier en Assurance Inc., we know that confidentiality of personal information is important. Any information you provide to us will be kept in a group life and health benefits file. Access to your information will be limited to:

- our employees and representatives in the performance of their jobs;
- persons to whom you have granted access in writing; and
- persons authorized by law.

You have the right to request access to the personal information in your file and, if necessary, correct any inaccurate information.

HED Courtier en Assurance Inc. is focused on respecting your privacy and maintaining confidentiality of information. We have safeguards in place to protect your personal, business, and financial information which adheres to the Ten Privacy Principles as covered by the Personal Information Protection and Electronic Document Act (www.privcom.gc.ca). To learn more about HED Courtier en Assurance Inc.'s commitment to privacy and security refer to our web site: www.hedinc.com/fr

Signature of Employee	Signed at: (city)	Date (yy/mm/dd)
Signature of Employer	Signed at: (city)	Date (yy/mm/dd)