DIBRINA SURE
Benefits Consulting Inc.

Horizon Plastics

EMPLOYEE ENROLMENT FORM

PERSONAL INFORMATION

Date of Birth | Gen

Last Name | First Name (in Full) | mm/dd/yyyy | ○ M

( ) | Telephone | Business E-mail

Address Information:

Street Number and Name | City | Province of Residence | Posta

Marital Status: ○ Single ○ Married ○ Common-Law Civil Union ○ Separated ○ ○ Divorced

Note If common-law please indicate the date of the beginning of cohabitation or separation: mm/dd/yyyy

Note If married, does your spouse have the same address as you? ○ Yes ○ No

COVERAGE INFORMATION

Do you have a Spousal Dependent? ○ Yes ○ No

Do you have a Child Dependent? ○ Yes ○ No

Health: ○ Single ○ Family ○ Waived*

Dental: ○ Single ○ Family ○ Waived*

*I am opting out as I and my dependents have Extended Health Care and Dental under my spouse's plan. I understand that I have 31 days after the termination of my spouse's this policy, or I and/or any eligible dependents will be required to furnish at my own expense, evidence of insurability satisfactory to the insurance company.

For Quebec residents (age 65 or over)

○ I am participating in the RAMQ drug plan provided by the Quebec government

◯ I am NOT participating in the RAMQ drug plan provided by the Quebec government

SPOUSE INFORMATION

Date of Birth

Last Name _____ First Name (in Full) _____ mm/dd/yyyy _____

Is your spouse employed? ◯ Yes ◯ No **Does your spouse have benefits?** ◯ Yes ◯ No **Effective Date:** ____

Note Co-ordination of Benefits - Your plan contains a co-ordination of benefit provision which allows for sharing the cost between two plans and ensures the employees r there is benefit coverage through your spouse's plan, please provide the following:

My Spouse:

Has **Health** coverage under his/her employer's plan: ◯ Yes ◯ No If yes, ◯ Single Coverage, or

Has **Dental** coverage under his/her employer's plan: ◯ Yes ◯ No If yes, ◯ Single Coverage, or

Other Insurer's Name: _____ Group/Contract No.: ____

DEPENDENT INFORMATION

Note Definition of a student is a dependent who has attained the minimum age eligibility but not the maximum and is attending a credited High School, College or Univer the mininum and maximum age limits.

Dependent 1 **Date of Birth** **Gender**

Last Name _____ First Name (in Full) _____ mm/dd/yyyy _____ ◯ M ◯ F

IF STUDENT: School Attending _____ **Start Date** _____ **End Date**

***PROOF REQUIRED** mm/dd/yyyy

Dependent 2 **Date of Birth** **Gender**

Last Name _____ First Name (in Full) _____ mm/dd/yyyy _____ ◯ M ◯ F

IF STUDENT: School Attending _____ **Start Date** _____ **End Date**

***PROOF REQUIRED** mm/dd/yyyy

Dependent 3 **Date of Birth** **Gender**

Last Name _____ First Name (in Full) _____ mm/dd/yyyy _____ ◯ M ◯ F

IF STUDENT: School Attending _____ **Start Date** _____ **End Date**

***PROOF REQUIRED**

mm/dd/yyyy

Dependent 4 **Date of Birth** **Gender**

Last Name | First Name (in Full) | mm/dd/yyyy | ○ M ○ F

IF STUDENT: School Attending **Start Date** **End Date**

***PROOF REQUIRED**

mm/dd/yyyy

BENEFICIARY DESIGNATION

Beneficiary for **Employee Life**, **Accidental Death Benefits**, **Optional Life** and **Optional Accidental Death Benefits** (if applicable)

Note You must complete the form in ink, sign and date the form. You must initial any changes or deletions, correction fluid cannot be used.

☐ I wish to designate the amount insured to my estate.

Last Name	First Name	Relationship to Emp

You may change this beneficiary designation at any time. If you wish to make the beneficiary designation irrevocable (meaning you may not change the designation or mak changes to your coverage under the plan without the written consent of the beneficiary) please check here:

Where Quebec law applies, your married spouse or civil union spouse as beneficiary is irrevocable unless you make the designation revocable by checking here:

You are responsible for ensuring the validity of your designation.

If you are nominating a beneficiary who is a minor (in your province of residence) or who lacks legal capacity, you may wish to appoint a trustee.

I designate _____ as Trustee. Relationship to employee _____

CONTINGENT BENEFICIARY DESIGNATION

If there are no surviving beneficiaries at time of death, I declare that the following Contingent Beneficiaries shall receive the proceeds. If there are no surviving Contingent B death, the proceeds shall be paid to my estate.

Note You must complete the form in ink, sign and date the form. You must initial any changes or deletions, correction fluid cannot be used.

Last Name	First Name	Relationship to Emp

You may change this contingent beneficiary designation at any time. If you wish to make the contingent beneficiary designation irrevocable (meaning you may not change t or make certain changes to your coverage under the plan without the written consent of the beneficiary) please check here:

Where Quebec law applies, your married spouse or civil union spouse as beneficiary is irrevocable unless you make the designation revocable by checking here:

You are responsible for ensuring the validity of your designation.

If you are nominating a beneficiary who is a minor (in your province of residence) or who lacks legal capacity, you may wish to appoint a trustee.

I designate _____ as Trustee. Relationship to employee _____

PROTECTING YOUR PERSONAL INFORMATION

The respective Insurance company or Third Party Administrator recognizes and respects the importance of privacy. When you apply for coverage, our administrators establis personal information in your file will be limited to persons authorized and who require it to perform their duties, to persons to whom you have granted access, and to persons determine your eligibility for coverage and to administer the group benefits plan.

AUTHORIZATION AND DECLARATIONS

• I hereby certify that the above statements are true, accurate and complete to the best of my knowledge and belief. I understand that any misinformation or false statement w termination of coverage and/or repayment of ineligible benefits. I hereby authorize my employer, the group plan administrator, third party administrator, and the Insurance C organization having any relevant information regarding me, my spouse or dependents to release and exchange any and all information necessary for the purposes of determin administration of the group benefits plan. I confirm I am authorized to act on behalf of my spouse and/or dependents for such purposes.

• I agree that a photocopy or electronic copy of this Authorization and Declaration section is as valid as the original

• I acknowledge that all information provided on this form is subject to audit.

_____ _____

Employee's Signature Date S

_____ _____

Employer's Signature Date S

TO BE COMPLETED BY THE EMPLOYER

○ **NEW** ○ **REHIRE** REASON: _____

Certificate No.: _____ **Division:** _____ **Unit:** _____ **Policy No.:** _____

Employment Date: _____ **Effective Date:** _____ **Province of Employment**

mm/dd/yyyy mm/dd/yyyy

Employee Occupation: _____ **Earnings:** $ _____ ○ Annual ○ Month

DiBrina Sure Benefits Consulting Inc.
62 Frood Rd. Suite 302
Sudbury, ON P3C 4Z3

ıder **Language**

○ ○ ○
F E F

Postal Code

○ Widowed

s plan to apply for Extended Health and Dental benefits under

Gender

○ ○

M F

_____

mm/dd/yyyy

eceive the maximum overall benefit between the two plans. If

○ Family Coverage

○ Family Coverage

_____

sity. Please refer to your booklet for

Student **Disabled**

☐ ☐

End Date _____

mm/dd/yyyy

Student **Disabled**

☐ ☐

End Date _____

mm/dd/yyyy

Student **Disabled**

☐ ☐

End Date _____

mm/dd/yyyy

Student	Disabled
☐	☐

End Date _____

mm/dd/yyyy

ɔloyee	%
e certain ☐ Irrevocable	
☐ Revocable	

(Not applicable in Quebec)

Beneficiaries at the time of my

ɔloyee	%
he designation ☐ Irrevocable	
☐ Revocable	

(Not applicable in Quebec)

[redacted]

sh a confidential file that is kept in their office. Access to
s authorized by law. The personal information is used to

[redacted]

vill affect my and my dependent's eligibility for benefits,
Company providing our benefits or any other person or
ıation of eligibility for benefits, proper payment of claims and

Signed

Signed

[redacted]

Cost Centre: _____

Province of Employment: _____

Monthly ○ Weekly ○ Bi-weekly