

HEALTH CARE PROVIDERS GROUP ENROLMENT FORM

Office Use Only

Open Window (Y/N) _____ Underwriting (Y/N) _____

CHOOSE YOUR COVERAGE:

Plan 1A:
 Disability, Life & ADD&D Only

EXTRA HEALTH CARE COVERAGE (OPTIONAL)

Exceptional Expenses Insurance (EEI)

Healthcare Incidental Insurance (HII)

PLAN 1 <input type="checkbox"/>	PLAN 2 <input type="checkbox"/>	PLAN 65+ <input type="checkbox"/>
Health Care Coverage <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Basic Dental <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enhanced Dental <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ADDITIONAL BENEFITS (OPTIONAL) Plan 1 only

Employee Long Term Disability <input type="checkbox"/>	Spouse Life Insurance <input type="checkbox"/>
Employee Life Insurance <input type="checkbox"/>	Child Life Insurance <input type="checkbox"/>

PLAN 65+: I wish to apply for *Essential level* only

LAST NAME: _____ FIRST NAME: _____ INITIAL: _____

_____ / _____ / _____ / _____
ADDRESS CITY PROVINCE POSTAL CODE

HOME TELEPHONE: (____) _____ EMAIL ADDRESS: _____

MALE FEMALE DATE OF BIRTH: (DD/MM/YYYY) _____

SINGLE MARRIED COMMON LAW (SEE DECLARATION OVERPAGE) SEPARATED DIVORCED WIDOWED

DEPENDENTS ENROLLMENT INFORMATION

ANY DEPENDENTS (Incl. spouse) ELIGIBLE FOR COVERAGE UNDER THIS PLAN MUST BE LISTED BELOW

Dependents	Surname	First Name	M/F	DOB (dd/mm/yyyy)	Full Time Student (Y/N) (age 21-25)
Spouse					
1 st Child					
2 nd Child					
3 rd Child					
4 th Child					

FOR EMPLOYEES ONLY (CURRENT POSITION)

PART TIME CASUAL

Date hired as Part Time/Casual: (dd/mm/yyyy) _____

Are you currently off on maternity, disability or any other kind of leave?
 YES NO

Average weekly hours: _____ Gross monthly salary: \$ _____

Occupation: _____

Hospital: _____ Site: _____

Hospital Tel: (____) _____ Ext.: _____

FOR RETIREES ONLY

RETIRED FROM HOSPITAL

Date Retired: (dd/mm/yyyy) _____

Last date of active work at hospital: (dd/mm/yyyy) _____

Hospital: _____

Site: _____

Complete beneficiary and/or trustee information only if you are applying for Plan 1

BENEFICIARY: _____ **RELATED TO ME AS:** _____

TRUSTEE : _____ **RELATED TO ME AS:** _____
(Name a Trustee if beneficiary is under age 18. Will expire when beneficiary reaches age 18)

Are you currently or have you within the past 60 days been, covered by a group health plan? IF SO, FILL OUT NEXT LINE

PROVIDED BY: _____ **INSURED THROUGH:** _____
Name of employer or other provider Name of Insurance Company

***APPLICATION FOR COMMON-LAW COVERAGE – DECLARATION**

I the undersigned, hereby certify that I have been living with _____ since (dd/mm/yyyy) _____ and representing him/her as my spouse or my (common-law) spouse. I further certify that I and/or my (common-law) spouse are solely responsible financially for either of our children claimed for insurance purposes. I further certify that I do not have or I do not wish to provide coverage to my legal spouse, if any.

REQUEST FOR PRE-AUTHORIZED PAYMENT PLAN

I hereby authorize Health Care Providers to arrange automatic deductions from the following account:
YOUR ACCOUNT MUST HAVE CHEQUING PRIVILEGES

Your name as shown on the account: _____

Name of your Bank: _____

Address of Bank: _____ City: _____ Postal Code: _____

Date: _____ Signature: **X** _____
(dd/mm/yyyy)

*Two (2) cheques are required with your application; please make them both payable to **Health Care Providers**. Also please ensure that these two (2) cheques are drawn on the account from which you wish us to withdraw your monthly premium.*

I hereby apply for benefit coverage from the Health Care Providers Group Insurance Plan™ for which I am eligible, and I authorize the hospital to release address, phone, and income information to the Plan Administrator if required. I acknowledge all information is complete and accurate. I understand that I and my dependents must be covered under my Provincial Health Plan in order to be eligible for Extended Health coverage. I understand that the Health evidence provided on me and my dependents as part of this application may be used by all parties involved in the issuing of my coverage and I hereby consent to such usage on behalf of myself and any dependents for whom coverage is sought. I understand that Health Care Providers Group Insurance Plan™ reserves the right to audit claims.

Acknowledgment

I understand coverage is effective on the first of the month following the date my application is approved, unless I elect to delay the effective date one month provided all of the following requirements have been met:

- A fully completed signed application and required premium has been received by Hardiman Mount & Associates Insurance Brokers Limited
- Underwriting approval (when underwriting is required)
- I continue to meet all eligibility rules

I understand that I must be actively at work on the effective date of coverage or coverage will be delayed until the first of the month following my return to active employment. (Does not apply to Retirees)

Date: _____ **Signature of Employee:** **X** _____

Privacy Statement

All information about the insurability of you and your dependents is considered confidential. Hardiman Mount & Associates Insurance Brokers Limited are committed to protecting the privacy, confidentiality, accuracy and security of the personal information that is collected, used, retained and disclosed in the course of conducting business.