Advanced Benefit Solutions Inc.

PO Box 1860, Didsbury, AB T0M 0W0

❑ **New Enrolment** ❑ **Changes to Existing Enrolment**

Today' Date: _____ ❑ New Hire / ❑ Re-Hire Effective Date: _____

Employer / Plan Section (to be completed by the plan administrator)

Company Name:_____ Policy No:_____

Date of Permanent Full-time:_____ Effective Date:_____

Occupation:_____ Earnings: _____

Class / Division:_____

Employee / Participant Details (to be completed by the employee)

Last Name:_____ First Name:_____ Middle Initial:___ M/F:_____

Address:_____

City:_____ Province:_____ Postal Code:_____

Phone Number (Home): _____ (Work): _____

Email Address:_____ Date of Birth: (mm/dd/yyyy):_____

Marital Status: _____ Select Coverage Status: ❑ Single ❑ Family

Dependent Details (to be completed by the employee)

Spouse: Last Name:_____ First:_____ Sex:___ DOB:_____

Child 1: Last Name:_____ First:_____ Sex:___ DOB:_____

Child 2: Last Name:_____ First:_____ Sex:___ DOB:_____

Child 3: Last Name:_____ First:_____ Sex:___ DOB:_____

Child 4: Last Name:_____ First:_____ Sex:___ DOB:_____

Please indicate below if any of your dependents are full time students over age 21

Name of Over Age Student	College/University Attended	Enrolled From	Enrolled To

Please indicate the name of any disabled dependents:_____

Co-ordination of Benefits / Refusal of Coverage (to be completed by the employee)

If you and/or your dependents are presently insured for Health Care and/or Dental benefits under your spouse's group policy you may co-ordinate benefits or refuse coverage under this contract by completing the appropriate areas.

My spouse has coverage through _____(Name of insurance company)
Policy number for spouse's plan_____

- ❑ I wish to co-ordinate coverage with my spouse's plan
- ❑ I refuse insurance on myself and dependents under: Health_____ Dental_____
- ❑ I refuse insurance on my dependents under: Health_____ Dental_____

Revocable Beneficiary Nomination (to be completed by the employee)

Beneficiary's Full Name	DOB	Relationship	Percentage Allocated
_____	_____	_____	_____%
_____	_____	_____	_____%
_____	_____	_____	_____%

Trustee's Full Name (See Below): _____

Please note that benefits cannot be paid to beneficiaries who are minors.
A trustee must be appointed (not applicable in Quebec).

Where Quebec law is applicable, a spouse beneficiary is irrevocable unless you make the designation revocable.

- ❑ I hereby make the designation Revocable

Stop Loss if applicable (to be completed by the employee)

As part of the Health benefit provided through my employer (myself and my dependents) wish to be insured under the group insurance stop loss protection program.

Note: For consideration under this policy the following questions must be completed

1. Have you or any of your dependents, on an individual basis, incurred more than $1,750.00 in health expenses in the last twelve (12) month period? ❑Yes ❑No
2. If yes, the approximate amount incurred $_____
3. Name of applicable person (dependent):_____DOB:_____

I hereby authorize the release of medical claims information solely for the purposes of determining eligibility and validating claims under this policy. I understand that this information can be forwarded to any other third party and will only be used for determining eligibility and validating the claim according to the terms of the Group Insurance Stop Loss Policy.

Authorization (to be completed by the employee)

By enrolling in this plan I am authorizing the applicable insurance carriers, agents and service providers to use and exchange information collected in this form to underwrite, administer and adjudicate claims. I also authorize my plan sponsor to use this same information for benefits administration and to make any necessary payroll deductions, which may be required.

Employee / Participant Signature:_____

Employee / Participant Name (Please Print):_____

Date:_____