734 – 13 Street N Lethbridge, Alberta T1H 2T1
403 328 9114 Phone
info@cvbenefits.com

Employee Application / Change Form

❑ Enrolment Form Date of Hire / Re-Hire: _____
❑ Change Form Type of Change:_____ Date Effective: _____

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

Company Name: _____ Policy No:_____

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

Occupation:_____ Annual Earnings: _____

Class / Division:_____

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

Last Name:_____ First Name:_____ M/F:__

Address:_____

_____

SIN (Certificate No.):_____ Date of Birth: (dd/mmm/yyyy):_____

Marital Status: _____ 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 _____(insurance company) under policy no_____

❑ 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____

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:_____