BENEFITS BY DESIGN

EMPLOYEE ENROLLMENT

Throughout this form, Benefits by Design is referred to as BBD.
Please complete this form, sign it, and submit it to your Plan Administrator.

SECTION 1: EMPLOYMENT INFORMATION (TO BE COMPLETED BY THE EMPLOYER)

Name of Employer		
Employee Last Name		Employee First Name
Employee Class	Employee Occupation	Employment Date (mm/dd/yyyy)
Eligibility Date (mm/dd/yyyy)		Date Reinstated (mm/dd/yyyy)
Employee Earnings $ ○ Annually ○ Monthly ○ Weekly ○ Hourly		Hours Worked per Week

I confirm that the employee is eligible to apply for benefits coverage and the information provided is true and complete.

Signature of the Employer **Date of Signature (mm/dd/yyyy)**

x _____ _____

SECTION 2A: EMPLOYEE INFORMATION (TO BE COMPLETED BY THE EMPLOYEE)

Home Address			City
Province	Postal Code	Date of Birth (mm/dd/yyyy)	Gender ○ Male ○ Female ○ Undisclosed
Language Preference ○ English ○ French			Phone Number

Email Address

_____

BBD respects your privacy. Your email address will only be used to contact you with information about claims or your benefits plan, unless otherwise specified in Section 6.

Marital Status
○ Single ○ Married ○ Widowed ○ Separated ○ Divorced ○ Common Law*

*Date of Cohabitation (mm/dd/yyyy) _____

Date of cohabitation is mandatory if Common Law. Common Law dependents are eligible for benefits after one year of cohabitation.

EMPLOYEE ENROLLMENT

SECTION 2B: EMPLOYEE INFORMATION (CONTINUED)

Are you covered under a provincial health plan? (OHIP, MSP, etc.) ○ Yes ○ No*

**If you don't have coverage through your provincial health plan, you still qualify for benefits with some restrictions. Your BBD Customer Service Representative will provide your employer with further details.*

Are you in Canada on a work visa/permit? ○ Yes* ○ No

*If yes, please provide an expiry date:_____

**If disability benefits are included in your group plan, you are eligible provided your work visa is one or more years, or if less than one year, you have applied for permanent residency. You must also have coverage under a provincial government health insurance plan.*

SECTION 3: DEPENDENT COVERAGE (TO BE COMPLETED BY THE EMPLOYEE)

Relation	Last Name	First Name	Date of Birth (mm/dd/yyyy)	Gender	Children over 21, name of school and/or disability
Spouse				○ Male ○ Female ○ Undisclosed	
				○ Male ○ Female ○ Undisclosed	
				○ Male ○ Female ○ Undisclosed	
				○ Male ○ Female ○ Undisclosed	

SECTION 4: WAIVER/COORDINATION OF BENEFITS

By completing this section, I elect to waive the benefits checked below because comparable coverage is provided to me and/or my dependents under another group plan.

Insurance Company	Group Number	ID Number

Waiver of Coverage for:

Myself and my dependents:	☐ Waive Extended Health ☐ Waive Dental	My dependents only:	☐ Waive Extended Health ☐ Waive Dental

Is this comparable coverage provided by a spouse's group plan? ○ Yes ○ No

If coverage is not provided by a spouse's group plan, please provide details below.

Coordination of Benefits Under Spouse's Plan:

Myself and my dependents:	☐ Coordinate Extended Health ☐ Coordinate Dental	My dependents only:	☐ Coordinate Extended Health ☐ Coordinate Dental

RAMQ Coverage (for Quebec residents aged 65 or older):

Member: ○ RAMQ ○ Private Coverage ○ Both	Spouse: ○ RAMQ ○ Private Coverage ○ Both

SECTION 5: BENEFICIARY DESIGNATION

If you name multiple beneficiaries, the total allocation must equal 100%. Death benefits will not be paid directly to a minor beneficiary; a date of birth must be provided for any beneficiary who is a minor. Outside Quebec, you should name a trustee for a minor beneficiary and any death benefits due to the beneficiary, while a minor, will be paid to the trustee on their behalf. In Quebec, death benefits due to a beneficiary, while a minor, will be paid to their parent(s) or legal guardian unless you have established a formal trust. After the beneficiary reaches the age of majority, any death benefits due to the beneficiary will be paid directly to the beneficiary unless you have established a formal trust and such trust is still in effect at the time the death benefit is due.

Irrevocable/Revocable Beneficiaries

Once an irrevocable beneficiary has been named, you cannot change or revoke the beneficiary without the irrevocable beneficiary's signature. A minor should not be designated as an irrevocable beneficiary. A minor irrevocable beneficiary cannot consent to a change of beneficiary and a parent or guardian may not sign on behalf of a minor child for this purpose. All beneficiaries are assumed revocable unless you check the irrevocable box, except in Quebec. In Quebec, if a married or civil union spouse is named the beneficiary, the designation is irrevocable unless otherwise indicated.

Full Legal Name	Relationship	Date of Birth (if a minor)	Share (percent)	Revocable Status
			%	○ Revocable ○ Irrevocable
			%	○ Revocable ○ Irrevocable
			%	○ Revocable ○ Irrevocable
			%	○ Revocable ○ Irrevocable
			%	○ Revocable ○ Irrevocable

Trustee Designation (required, if beneficiary is a minor)

Trustee's Full Legal Name

SECTION 6: EXPRESS CONSENT UNDER THE CANADIAN ANTI-SPAM LAW (CASL)

BBD will use the email provided in Section 2 to contact you with information pertaining to the administration of your benefits plan including claims.

Occasionally, BBD would like to send you promotional notifications to make sure you are in the know about the latest and greatest products and services we are offering.

In compliance with CASL, by checking the box on the next page, you expressly consent to receiving, during and after your receipt of benefits coverage through BBD, commercial electronic messages (CEMs), including emails, from BBD providing information to you through BBD newsletters, updates, alerts, other electronic publications and communications regarding information on BBD's services, including marketing of personal benefits.

SECTION 6: EXPRESS CONSENT UNDER THE CANADIAN ANTI-SPAM LAW (CASL) CONT.

To Unsubscribe: At any time, you may withdraw this consent or modify your preference as to the types of CEMs you receive from BBD by notifying BBD at 1-888-272-0413, by visiting the Subscription Centre on BBD's website, or by using the unsubscribe mechanism in any BBD CEM.

○ Yes, I consent. Please contact me using the email provided in Section 2.

○ No, I do not consent. I will continue to receive emails related to my benefits plan and claims.

○ Yes, I consent. Please email me using the below email address:

_____

SECTION 7: EMPLOYEE CONFIRMATION

I ACKNOWLEDGE AND AGREE that the contract(s) between my employer and the insurer(s) and service providers of my benefits coverage requires deductions for contributions from my earnings and I AUTHORIZE my employer to make all such deductions.

I AUTHORIZE BBD to collect, use and disclose my personal information and the personal information of my dependents and beneficiaries for my benefits coverage in accordance with BBD's privacy policy in effect from time to time. The most recent version of BBD's Privacy Policy can be found on the BBD website. My continued provision of personal information to BBD or my continued use of BBD's services following any changes to BBD's Privacy Policy constitutes my acceptance of any changes to BBD's Privacy Policy from time to time.

I UNDERSTAND that this original document and all other personal information pertaining to me and my dependents and beneficiaries for my benefits coverage are in the property of BBD and will be retained by BBD in accordance with its record keeping requirements and as required by law, regulatory requirements and BBD's contractual arrangements.

I CONFIRM that the information I have provided in this form is true, correct, and complete.

Signature of the Employee **Date of Signature** (mm/dd/yyyy)

X _____ _____

SECTION 8: DISCLOSURE

At BBD, we are committed to protecting the privacy and the confidentiality of your personal information we collect concerning you and your dependents. Your personal information is stored by BBD in accordance with our Privacy Policy. You have the right to request access to your personal information and, if necessary, correct any inaccurate information. To do so, please contact your Plan Administrator. Access to your personal information will be limited to as set forth in our Privacy Policy.

SECTION 9: FORM SUBMISSION (FOR PLAN ADMINISTRATORS)

As a Plan Administrator, if you use Nomad to update employee information, please retain this form for your records. If you do not use Nomad, submit a copy of this form to your BBD Client Manager by email, or by mail, and retain the original. You can submit a copy of the form:

Online: Nomad Portal

By Mail:

Company located in British Columbia

Benefits by Design (BBD)
601 – 4180 Lougheed Highway
Burnaby, BC
V5C 6A7

Company located in all other provinces

Benefits by Design (BBD)
107-6 Cataraqui Street
Kingston, ON
K7K 1Z7

PRINT FORM

RESET FORM