



# 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 PLAN ADMINISTRATOR)

Name of Employer/Company Name		Division Name/Number	
Employee Last Name		Employee First Name	
Employee Class/Number	Employee Occupation	Permanent Date of Hire (mm/dd/yyyy)	
Coverage Effective Date (mm/dd/yyyy)		Date Reinstated (mm/dd/yyyy)	
If you waived the waiting period*, please explain why: (*must be submitted within 31 days of hire date)			
Employee Earnings		Hours Worked per Week	
\$ _____ Annually    Monthly    Weekly    Hourly			
I confirm that the employee is eligible to apply for benefits coverage and the information provided is true and complete.			
<b>Signature of the Plan Administrator</b>		<b>Date of Signature (mm/dd/yyyy)</b>	
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
Status Indian Yes    No    If yes, please provide your Status Number: _____			
Language Preference English    French		Phone Number	
Email Address _____			
<i>BBD respects your privacy. Your email address will only be used to contact you with information about claims or your benefits plan.</i>			

# EMPLOYEE ENROLLMENT

## SECTION 2B: EMPLOYEE INFORMATION (CONTINUED)

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*

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 may still qualify for some benefits. 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 for one or more years, or if less than one year, you have applied for permanent residency. You must also have coverage under a provincial health insurance or interim provincial replacement plan.*

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

Note: Please include all dependents regardless of your coverage status.

<b>Relation</b>	Spouse					
<b>Last Name</b>						
<b>First Name</b>						
<b>Date of Birth</b> (mm/dd/yyyy)						
<b>Gender</b>	Male Female Undisclosed	Male Female Undisclosed	Male Female Undisclosed	Male Female Undisclosed		
<b>Provincial health plan coverage?</b>	Yes No	Yes No	Yes No	Yes No		
<b>Indian Status</b>	Yes No	Yes No	Yes No	Yes No		
<b>Overage* Dependent Children</b>	Full time student		Full time student		Full time student	
	Yes	No	Yes	No	Yes	No
	Total Disability <sup>1</sup>		Total Disability <sup>1</sup>		Total Disability <sup>1</sup>	
Yes	No	Yes	No	Yes	No	

\*The age limit may vary depending on your plan. Please contact your plan administrator to confirm this information.

Children over an age as specified in your Benefit Booklet are eligible for coverage provided they are enrolled at an accredited school/college/university as a full-time student. Coverage will be extended up to September 30th of the next school year, the upper limit of the dependent definition age, or until coverage is terminated.

<sup>1</sup>- Total Disability - if yes, please include copy of the CRA's Disability Tax Credit approval letter with this application.

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## 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
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### Waiver of Coverage for:

Myself and my dependents:	<input type="checkbox"/> Waive Extended Health <input type="checkbox"/> Waive Dental	My dependents only:	<input type="checkbox"/> Waive Extended Health <input type="checkbox"/> Waive Dental
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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:	<input type="checkbox"/> Coordinate Extended Health <input type="checkbox"/> Coordinate Dental	My dependents only:	<input type="checkbox"/> Coordinate Extended Health <input type="checkbox"/> Coordinate Dental
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### RAMQ Coverage (for Quebec residents aged 65 or older):

Member:	<input type="checkbox"/> RAMQ	<input type="checkbox"/> Private Coverage	<input type="checkbox"/> Both	Spouse:	<input type="checkbox"/> RAMQ	<input type="checkbox"/> Private Coverage	<input type="checkbox"/> Both
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## SECTION 5: BENEFICIARY DESIGNATION

**If you name multiple beneficiaries, their total allocation must equal 100%.** If you name more than one beneficiary and do not indicate a share percentage, the death benefits will be divided equally among all surviving beneficiaries. Death benefits cannot be paid directly to a minor; you must provide the minor's date of birth. **Outside Quebec** - Name a trustee for any minor beneficiary; benefits are paid to the trustee until the beneficiary reaches the age of majority. **In Quebec** - Benefits for a minor are paid to the parent(s) or legal guardian unless a formal trust exists. After the age of majority, benefits are paid directly to the beneficiary unless a formal trust remains in effect.

### Irrevocable vs. Revocable Beneficiaries

You cannot change an irrevocable beneficiary without their signature. Minors should not be named irrevocable beneficiaries, as they cannot consent to changes and a parent/guardian cannot sign for them. All beneficiaries are considered revocable unless marked otherwise, except in Quebec, where a married or civil union spouse is automatically irrevocable unless specified.

### Primary vs. Contingent Beneficiaries

A primary beneficiary receives benefits if alive at your death. A contingent beneficiary receives benefits only if the primary beneficiary has predeceased you.

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## SECTION 5: BENEFICIARY DESIGNATION

PRIMARY BENEFICIARY		Relationship	Date of Birth (if a minor)	Share (percent)	Revocable	Irrevocable
First Name	Last Name					
				%		
				%		
				%		
				%		

## CONTINGENT BENEFICIARY

				%		
				%		

## Trustee Designation (required, if beneficiary is a minor)

Trustee's Full Legal Name	Relationship to you
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## SECTION 6: 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** \_\_\_\_\_

# EMPLOYEE ENROLLMENT

## SECTION 7: 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 8: 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:	<b>Company located in British Columbia</b>	<b>Company located in all other provinces</b>
	Benefits by Design (BBD) 601 – 4180 Lougheed Highway Burnaby, BC V5C 6A7	Benefits by Design (BBD) 107-6 Cataraqui Street Kingston, ON K7K 1Z7