ENROLMENT FORM
PEI CUPE LOCAL 1145, 1770, 1775, 3260

Check (✓)

☐ **ENROLMENT** **OR** ☐ **CHANGE:** **CHANGE DATE:** _____
☐ 10 Month
☐ 12 Month

☐ Name ☐ Termination
☐ Address ☐ Reinstatement
☐ Dependents ☐ Other: _____

MEMBER INFORMATION				
	(First Name) (Initials) Last Name			Payroll No.
	Date of Birth (DDMMYY)	Date of Hire (DDMMYY):	Gender: ☐ Female ☐ Male	Social Insurance No.
	Address: (Street No./P.O. Box) City or Town Province Postal Code			
	Home Tel:	Work Tel:	Cell:	e-mail:

FAMILY INFORMATION To ensure you are enrolled for all benefits for which you are eligible, you must report any change to spousal/dependent status to Johnson Inc. within 31 days of the change. Include Last Name if different from your last name (last, first, initial)	Spouse / Child Name - must be completed if you have a spouse and/or dependent children. If employee and spouse are not legally married, please provide commencement of date of co-habitation (DD / MM/ YY):_____	Date of Birth (DD / MM / YY)	Gender M / F	Dependent Status S- Student D - Disabled
	Spouse			
	Child			
	Child:			
	Child			
	Child			

APPLICATION INFORMATION

Basic Life and Blanket Life, Basic and Blanket Accidental Death & Dismemberment Insurance, and Basic Dependent Life are mandatory for all eligible employees.

You may waive Health and Dental coverage only if you have coverage under your spouse's plan

Health and Dental: Do you and /or dependents have coverage under another Health or Dental Plan? ☐ Yes ☐ No. If yes, please provide: Effective date (DD / MM/ YY):_____ Insurance Company and Policy No._____

Health:	☐ Single	☐ Family	☐ Waive
Dental Basic & Major Restorative:	☐ Single	☐ Family	☐ Waive
Travel:	☐ Single	☐ Family	☐ Waive

Basic Dependent Life – Mandatory.

Optional Life Insurance: (First $30,000 of coverage is available without medical evidence during eligibility period. Amounts above $30,000 will require an Evidence of Insurability form to be completed. Coverage is available in increments of $10,000 to a maximum of $300,000)

☐ Employee Coverage	Amount Applied For: _____	☐ Declined
☐ Spousal Coverage	Amount Applied For: _____	☐ Declined
☐ Dependent Child	$10,000 per dependent child	☐ Declined

Voluntary Accidental Death & Dismemberment Coverage: Do you and / or your dependents have coverage under another Voluntary AD&D Insurance Plan? ☐ Yes ☐ No. If yes, effective date (dd/mm/yy):

☐ Employee Only	☐ Employee-Children	☐ Family	Amount Applied For: $_____	☐ Declined

If requesting family coverage, please provide spouse's employer: _____

Optional Critical Illness: (First $50,000 of coverage is available without medical evidence. Amounts above $50,000 will require an Evidence of Insurability form to be completed. Available in units of $10,000 to a maximum of $250,000)

☐ Employee Coverage ☐ Smoker ☐ Non-Smoker	Amount Applied For: _____	☐ Declined
☐ Spousal Coverage ☐ Smoker ☐ Non-Smoker	Amount Applied For: _____	☐ Declined

AUTHORIZATION & DECLARATIONS

I hereby apply for benefits under the Public Sector Group Insurance Plan Benefit Plan and authorize any required payroll / bank deductions and consent to the use of my Social Insurance Number, if required, for the purpose of tax reporting, identification, or record keeping under the Plan.
In order to determine my eligibility for benefits and administer group benefit coverage(s), I give Johnson Inc. (and any relevant carrier as may be applicable) consent to:
Collect and communicate personal information about me from people or organizations including: any health care practitioner, medical facility or provider of health care / dental services, any provincial health insurance plan, insurance company or reinsurer, my plan sponsor or former plan sponsor, government agency or financial institution(s).
If applying for coverage for my spouse and / or dependents, I have consent to collect, use and communicate their personal information for the purposes listed above.
I acknowledge that more detailed information concerning how and why Johnson Inc. collects, uses and discloses my personal information is available at www.johnson.ca.
If I have declined coverage, I understand that I may not be able to obtain coverage at a later date if I change my mind. My ability to obtain coverage is subject to the specific requirements and rules of the applicable insurance program. I am solely responsible for the decisions to decline or accept coverage reflected in this enrolment form. I understand that I may not make a claim for any loss or damage arising directly or indirectly from the elections made in this form or from my participation in the Plan against the Public Sector Group Insurance Plan Benefit Plan, the Public Sector Group Insurance Trustees or their successors, or any service provider, employee or agent of the Plan or the Trustees. In signing this form I, and my spouse if applicable, specifically release those parties from any such liability.
The information given on this form is true, correct and complete to the best of my knowledge.

EMPLOYEE SIGNATURE | SPOUSAL SIGNATURE (IF APPLICABLE) | DD / MM / YY