



# CDCS HEALTH CLAIMS INC.

## Benefit Application Form

| Employer Information             |  |
|----------------------------------|--|
| Group Name: _____                | Group Number: _____                                      |
| Effective Date: _____<br>(d/m/y) | Action Code: _____<br>A=Add C=Change T=Transfer D=Delete |

| Employee Information   |   |
|--|---|
| Last Name: _____   | First Name: _____   |
| Date Of Birth: _____<br>(d/m/y)  | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Common-law* |   |
| *If common-law, date of cohabitation: _____<br>(d/m/y)   |   |
| Address: _____   |   |
| Suite: _____   | City: _____   |
| Province: _____  | Postal Code: _____  |
| Preferred language: <input type="checkbox"/> English <input type="checkbox"/> French   |   |

| Employment Information   |                   |             |              |
|--|-------------------|-------------|--------------|
| Date of Hire: _____<br>(d/m/y)   | Occupation: _____ |             |              |
| Certificate #: _____   | Division: _____   | Unit: _____ | Class: _____ |
| Salary Amount: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually <input type="checkbox"/> Hourly _____ | hours per week    |             |              |

| Coverage Information  |  |
|---|--|
| Dependent Group Life: <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| Health Status: <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Waived (Waiver due to spousal coverage – complete section below). |  |
| Dental Status: <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Waived (Waiver due to spousal coverage – complete section below). |  |

| Spousal Information/Coordination of Benefits   |  |
|--|--|
| Is your spouse covered for Extended Health benefits (may include Drugs) by their employer's plan <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| If spouse has coverage, indicate: <input type="checkbox"/> Single <input type="checkbox"/> Family  |  |
| Is your spouse covered for Dental benefits by their employer's plan <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| If spouse has coverage, indicate: <input type="checkbox"/> Single <input type="checkbox"/> Family  |  |
| <b>Waived:</b> I am waiving coverage for myself and my dependents as we have Health Coverage under my spouse's plan. I understand that I have 31 days after the termination of my spouse's plan to apply for Extended Health Care benefits under this policy, or I and/or any eligible dependents will be required to furnish at my own expense, evidence of insurability satisfactory to the insurance company. |  |

**Complete and sign back of form**



## Benefit Application Form

| Dependent Information    |   |                           |  |            |                              |                          |   |
|--------------------------|---|---------------------------|--|------------|------------------------------|--------------------------|---|
| Relationship to Employee | Action<br>A=Add<br>D=Delete<br>C=Change | Effective Date<br>(d/m/y) | Last Name<br>If Different<br>From Employee | First Name | Gender<br>M=Male<br>F=Female | Date of Birth<br>(d/m/y) | School or Infirm<br>(please refer to *) |
| spouse                   |   |                           |  |            |                              |                          |   |
| dependent                |   |                           |  |            |                              |                          |   |
| dependent                |   |                           |  |            |                              |                          |   |
| dependent                |   |                           |  |            |                              |                          |   |
| dependent                |   |                           |  |            |                              |                          |   |
| dependent                |   |                           |  |            |                              |                          |   |

| *Additional Overage Dependent Information |   |            |           |
|---|---|------------|-----------|
| Name of overage student                   | University/College (or Disability, if applicable) | Start Date | Stop Date |
|   |   |            |           |
|   |   |            |           |
|   |   |            |           |

| Beneficiary Designation |                |                          |  |
|-------------------------|----------------|--------------------------|--|
| Beneficiary Name        | Percentage (%) | Relationship to Employee | If beneficiary is a minor, Name of Trustee |
|                         |                |                          |  |
|                         |                |                          |  |
|                         |                |                          |  |

I, the undersigned employee/member, hereby appoint the person(s) stated as my beneficiary(ies) on my employers current and future insurance benefits and understand that I may, without restriction, change my beneficiary at any time in the future. For Quebec only, if spouse is beneficiary, their designation is: revocable  irrevocable

\_\_\_\_\_

|                             |                            |
|-----------------------------|----------------------------|
| <b>Employee's Signature</b> | <b>Date Signed (d/m/y)</b> |
|-----------------------------|----------------------------|

|   |  |  |  |  |  |  |  |  |  |                                      |
|---|--|--|--|--|--|--|--|--|--|--------------------------------------|
| <input type="checkbox"/> I hereby authorize my employer to use my social insurance number as the certificate number for my group benefits plan. | Enter SIN here:<br><table style="width: 100%; text-align: center;"> <tr><td style="border: 1px solid black; width: 20px; height: 20px;"> </td><td style="border: 1px solid black; width: 20px; height: 20px;"> </td><td style="border: 1px solid black; width: 20px; height: 20px;"> </td><td style="border: 1px solid black; width: 20px; height: 20px;"> </td><td style="border: 1px solid black; width: 20px; height: 20px;"> </td><td style="border: 1px solid black; width: 20px; height: 20px;"> </td><td style="border: 1px solid black; width: 20px; height: 20px;"> </td><td style="border: 1px solid black; width: 20px; height: 20px;"> </td></tr> </table> |  |  |  |  |  |  |  |  | _____<br><b>Employee's Signature</b> |
|   |  |  |  |  |  |  |  |  |  |                                      |

|  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> I hereby apply for benefits, for which I am or may become eligible and authorize payroll deductions, if required. I understand CDCS may release statistical information regarding claims paid on behalf of myself and my eligible dependents other than specific details related to a medical condition to my employer. CDCS will maintain an enrolment card file, an underwriting file, and claim files as deemed necessary. | _____<br><b>Employee's Signature</b> |
|--|--------------------------------------|

| Employers Authorization              |                                     |
|--------------------------------------|-------------------------------------|
| _____<br><b>Employer's Signature</b> | _____<br><b>Date Signed (d/m/y)</b> |

CDCS Enrolment Form 2004