# CDCS HEALTH CLAIMS INC.

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## ENROLLMENT

*INDICATES REQUIRED FIELDS

| CDCS GROUP #: | ***EMPLOYER NAME** |
|---|---|

## EMPLOYEE INFORMATION

| *TRANSACTION TYPE: ❑ ADD; ❑ DELETE; OR ❑ CHANGE | | *EFFECTIVE DATE OF TRANSACTION: (d/m/y): | |
|---|---|---|---|
| IF TRANSACTION TYPE IS A CHANGE, INDICATE NATURE OF CHANGE: | | | |
| ***EMPLOYEE LAST NAME**: | | ***FIRST NAME**: | |
| *ADDRESS: | | *CITY: | *POSTAL CODE: |
| *PROV. OF RESIDENCE: | *PROV. OF EMPLOYMENT: | ***BIRTH DATE: (d/m/y):** | ***DATE HIRED: (d/m/y)**: |
| ***STATUS: ❑ SINGLE OR ❑ FAMILY** | | SEX: ❑ MALE OR ❑ FEMALE or ❑ OTHER | |
| ***EMPLOYEE PHONE NUMBER** | | EMPLOYEE EMAIL | |

## DEPENDANT INFORMATION

| RELATIONSHIP TO EMPLOYEE If overage then Infirm? Or School? | *ACTION A: Add D: Delete C: Change | *EFFECTIVE DATE (d/m/y) | *LAST NAME IF DIFFERENT FROM EMPLOYEE | *FIRST NAME | SEX (M/F/O) | *DATE OF BIRTH (d/m/y) | STUDENT (Y/N). IF Y, THEN EXPECTED GRADUATION DATE (d/m/y) |
|---|---|---|---|---|---|---|---|
| SPOUSE | | | | | | | IF EMPLOYED SEE BELOW |
| Dependant | | | | | | | Y/N Graduation: / / |
| Dependant | | | | | | | Y/N Graduation: / / |
| Dependant | | | | | | | Y/N Graduation: / / |
| Dependant | | | | | | | Y/N Graduation: / / |
| Dependant | | | | | | | Y/N Graduation: / / |

## CO ORDINATION OF BENEFITS (COB) DECLARATION

**COORDINATION OF BENEFITS** between spousal plans is a method whereby one spouse's Plan is designated Primary, and the other is designated Secondary. The Primary Plan is the one with the spouse with the earlier birth date in the year (i.e. July 6 versus August 20), regardless of age. The Primary Plan pays first for all dependants claims and for his/her own claims. Claims submitted to a Secondary Plan for dependants must first have been submitted to the Primary Plan carrier. Failure to submit claims in the manner as described above and in accordance with the rules governing the Co ordination of Benefits, may result in any combination of the following:

Repayment in full to my employer for any spousal and/or dependant claims.
Payment to my employer for any legal and/or collection costs incurred.

I CERTIFY THAT MY SPOUSE

Check one:
- ❑ is not employed OR
- ❑ has no Plan available OR
- ❑ has a Plan available provided by_____ (Insurance Company or Plan Administrator), AND that my spouse if not currently enrolled in that Plan will now enroll in that Plan as provided by his/her employer.

**I ALSO CERTIFY** that if this status changes I will inform my employer and/or plan administrator immediately.

DATE: _____ **EMPLOYEE SIGNATURE**: _____

## SPOUSAL EXEMPTION

**IF SPOUSAL EXEMPTION IS REQUESTED PLEASE COMPLETE THE FOLLOWING:**

❑ I claim spousal exemption under the Plan because I have similar coverage with my Spouse's Plan.
My spouse is currently insured through a Plan underwritten by_____ (*Insurance Company).*

**DATE**:_____ EMPLOYEE **SIGNATURE**: _____

| CERTIFICATE #: | DIVISION: | UNIT: | CLASS: |
|---|---|---|---|

***DATE**: _____ ***EMPLOYER AUTHORIZED SIGNATURE**:_____