

**Small Town Plan  
Benefit Enrollment Form**



**1. TO BE COMPLETED BY EMPLOYEE (PLEASE PRINT) AND MAIL TO MARY GALWAY AT THE ABOVE ADDRESS OR FAX TO 1.888.584.6789**

**Member/Employee** \_\_\_\_\_ **SIN** \_\_\_\_\_  
First Name(s) Last Name

**Municipality** \_\_\_\_\_ **Division** \_\_\_\_\_

**Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Gender**  Male,  Female  
DAY MON YR

	Birth Date			Sex M/F	Children Status if over age 21 S = Student D = Disabled	<b>Member/Employee Address</b>
	Day	Mon	Yr			
Spouse						Street _____ City or Town _____
Dependent Children						Province _____ Postal Code _____ Telephone # (____) _____

**2. BENEFITS**

**A.**  Health:  Single  Couple  Family  
**B.**  Dental:  Single  Couple  Family  
**C.**  **Optional Benefits** (Please consult your Employer or Plan Administrator for information on Optional Benefits)

**3. WAIVER OF BENEFITS**

I **DO NOT** require  Health  Dental as I am currently covered through my spouse's plan, as indicated below. I understand that to enrol at a later date I may have to provide evidence of insurability.

Employer \_\_\_\_\_ Insurance Company \_\_\_\_\_

**X Signature of Insured** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_  
DAY MON YR

**4. CO-ORDINATION OF BENEFITS**

With Co-ordination of Benefits, you may be able to obtain reimbursement up to 100% of your eligible expenses. Please indicate coverage level (single/couple/family), your spouse/dependent has with another insurance provider

Name of Family Member: \_\_\_\_\_ Insurance Company: \_\_\_\_\_  
 Health:  Single  Couple  Family  
 Dental:  Single  Couple  Family  
 Policy Number: \_\_\_\_\_

**5. BENEFICIARY DESIGNATION**

I name the following Beneficiary and reserve the right to change or cancel this at a later date

\_\_\_\_\_  
First Name(s) Last Name Relationship Date of Birth DAY / MON / YR

If Beneficiary is under 18, please name Trustee. \_\_\_\_\_  
First Name(s) Last Name

In the event that my Beneficiary predeceases me, the following Contingent Beneficiary shall be entitled to the benefits:

Name: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
DAY MON YR

**X Signature of Insured** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_  
DAY MON YR

**6.** I hereby apply for benefits under my Employer's plan and authorize any required payroll deductions. I consent to the use of my Social Insurance Number by any insurer or administrator for record keeping, file identification, and/or reporting purposes. For our full privacy statement please visit [www.johnson.ca](http://www.johnson.ca)

**X Signature of Insured** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_  
DAY MON YR

**7. TO BE COMPLETED BY EMPLOYER (PLEASE PRINT)**

Full-time Permanent  Part-time Permanent  Elected Members

Annual Earnings:\$ \_\_\_\_\_ Earnings per:  Hour \$ \_\_\_\_\_  Week \$ \_\_\_\_\_  Month \$ \_\_\_\_\_

**Date of Hire** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Effective Date of Coverage** \_\_\_\_/\_\_\_\_/\_\_\_\_  
DAY MON YR DAY MON YR