

Mail To: Architype Benefits #206 – 1220 Falcon Drive, Coquitlam, B.C. V3E 2E5
Phone: (604) 942-2299 Email to: Greg@ArchitypeFinancial.com



EMPLOYEE ENROLMENT / CHANGE FORM

New Enrolment Date of Hire / Re-Hire: _____ Termination Date: _____
Change Type of Change: _____ Date Effective: _____
Termination

Employer / Plan Section (to be completed by the plan administrator)

Company Name: _____ **Policy No:** _____
 Date of Permanent Full-time: _____ Effective Date: _____
 Occupation: _____ Annual Earnings: _____
 Class / Division: _____

Employee / Participant Details (to be completed by the employee)

Last Name: _____ First Name: _____ M/F: _____
 Address: _____
 _____ Email Address: _____
 SIN (Certificate No.): _____ Date of Birth: (dd/mm/yyyy): _____
 Marital Status: _____ Coverage Status: Single: _____ Family: _____

Dependent Details (to be completed by the employee)

Spouse: Last Name: _____ First: _____ Sex: _____ DOB: _____
 Child 1: Last Name: _____ First: _____ Sex: _____ DOB: _____
 Child 2: Last Name: _____ First: _____ Sex: _____ DOB: _____
 Child 3: Last Name: _____ First: _____ Sex: _____ DOB: _____
 Child 4: Last Name: _____ First: _____ Sex: _____ DOB: _____

Please indicate below if any of your dependents are full time students over age 21

Name of Over Age Student	College/University Attended	Enrolled From Date	Enrolled To
_____	_____	_____	_____
_____	_____	_____	_____

Please indicate the name of any disabled dependents: _____

Co-ordination of Benefits / Refusal of Coverage (to be completed by the employee)

If you and/or your dependents are presently insured for Health Care and/or Dental benefits under your spouse's group policy you may co-ordinate benefits or refuse coverage under this contract by completing the appropriate areas.

My spouse has coverage through _____ (insurance company) under policy no _____

I wish to co-ordinate coverage with my spouse's plan





- I refuse insurance on myself and dependents under: Health _____ Dental _____
- I refuse insurance on my dependents under: Health _____ Dental _____

Revocable Beneficiary Nomination (to be completed by the employee)

Beneficiary's Full Name	DOB	Relationship	Percentage Allocated
_____	_____	_____	_____ %
_____	_____	_____	_____ %
_____	_____	_____	_____ %

Trustee's Full Name (See Below): _____

Please note that benefits cannot be paid to beneficiaries who are minors. A trustee must be appointed (not applicable in Quebec).

Where Quebec law is applicable, a spouse beneficiary is irrevocable unless you make the designation revocable.

I hereby make the designation Revocable

Not Applicable

Stop Loss (to be completed by the employee)

As part of the Health benefit provided through my employer (myself and my dependents) wish to be insured under the group insurance stop loss protection program:

Note: For consideration under this policy the following questions must be completed

- Have you or any of your dependents, on an individual basis, incurred more than \$1,750.00 in health expenses in the last twelve (12) month period?

Yes: _____ No: _____ If yes, the approximate amount incurred \$ _____

Name of applicable person (dependent): _____ DOB: _____

I hereby authorize the release of medical claims information solely for the purposes of determining eligibility and validating claims under this policy. I understand that this information can be forwarded to any other third party and will only be used for determining eligibility and validating the claim according to the terms of the Group Insurance Stop Loss Policy.

Authorization (to be completed by the employee) or Employer

By enrolling in this plan I am authorizing the applicable insurance carriers, agents and service providers to use and exchange information collected in this form to underwrite, administer and adjudicate claims. I also authorize my plan sponsor to use this same information for benefits administration and to make any necessary payroll deductions, which may be required.

Employee / Participant Signature: _____ **X**

Employee / Participant Name (Please Print): _____

Date: _____

Administrator Signature _____ **X**

If this is an employee termination, please note the employee cost sharing % for this employee so we can calculate his/her return of premium, and/or the credit of premium to your employer's account.

Cost Sharing % _____