

Plan member application



New employee Reinstatement

Plan member: Please print clearly. Complete sections 1-5, and return the form to your plan administrator.

Plan administrator: Please complete sections 6 and 7 and submit to Sirius Benefits.

1	Plan member information	Last name		First name						
		Mailing address			City	Province	Postal code			
		Email address			Daytime phone number		Language <input type="checkbox"/> English <input type="checkbox"/> French			
		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of birth DD/MM/YYYY		Provincial health plan coverage <input type="checkbox"/> Yes <input type="checkbox"/> No		Indian status <input type="checkbox"/> Yes <input type="checkbox"/> No	SCIS Number	
		Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Common-law - Date of co-habitation: _____								
2	Other coverage	Does your spouse have coverage through their employer? Name of your spouse's group insurer: _____ Plan number: _____					Extended Health Care <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental <input type="checkbox"/> Yes <input type="checkbox"/> No		
		Complete this section if you have a spouse. Are you covered for health and/or dental benefits under your spouse's plan?					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		If yes:	I want to decline benefits for myself and my dependants OR				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
			I want to decline benefits for my dependants but maintain coverage for myself				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
3	Dependant Information	Name		Date of birth DD/MM/YYYY	Gender M or F	Relationship to plan member	For over age dependent children, see booklet for definitions of each		Indian status	
		Last	First				Full-time university or college student?*	Disabled dependant*		
		Spouse						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Child						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Child						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
*Please complete an Over Age Dependant Application if the dependent child is attending college or university or if he/she is an over age disabled dependant. Your plan administrator can provide more information.										
4	Beneficiary	Name		Relationship to plan member	Percentage cannot exceed 100%	For Quebec residents only: Any designation of a spouse is considered irrevocable unless you check here <input type="checkbox"/> to stipulate that the designation of the spouse is revocable.				
		Last	First							
Trustee designation	This section is to be completed only if the beneficiary designated above is under the age of majority.			I hereby appoint _____ as trustee to receive any amount due to any beneficiary under the age of 18.						
5 I consent to the collecting, using and disclosing of my personal information for the purposes of communication, underwriting risks, investigating and adjudicating claims, detecting and preventing fraud, compiling statistics and acting as required or authorized by law. I certify that all information in this form is true and accurate. I hereby apply for coverage for which I am, or may become, eligible for. I acknowledge that I only enroll, at this time or any future time, dependants that have authorized me to provide their information and consent to the collection, use and disclosure of their information for the above purposes. I authorize Sirius Benefits, any insurance companies and healthcare providers to exchange information when necessary to determine eligibility and to administer the plan. I designate the above mentioned beneficiary for any benefits payable as a result of my participation in this plan.										
Plan member signature					Date signed DD/MM/YYYY					
6	Plan administrator	Group no.	Firm no.	Class		Name of firm				
		Occupation		Permanent date of hire		Number of hours worked per week		Gross monthly earnings		
7	I confirm that this employee is eligible for coverage and that the information provided is true and accurate.									
	Plan administrator signature					Date signed DD/MM/YYYY				

Sirius Benefits use only:

8	Group _____	Firm _____	Cert _____	Member _____	Class _____	Eff date _____
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