

# NEBS EMPLOYEE ENROLMENT FORM GROUP INSURANCE & PENSION

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ALL ELIGIBLE EMPLOYEES MUST COMPLETE AND SUBMIT THIS ENROLMENT FORM WITHIN 31 DAYS OF THEIR EFFECTIVE DATE OF COVERAGE. EFFECTIVE DATE = HIRE DATE + PLAN WAITING PERIOD. IF THE FORM IS NOT RECEIVED WITHIN THIS TIMELINE MEDICAL UNDERWRITING WILL BE REQUIRED AND COVERAGE MAY BE DELAYED OR DENIED AND THE EMPLOYEE WILL NOT EARN CREDITED SERVICE TOWARD THEIR PENSION

ALL FULL TIME EMPLOYEES ARE CONSIDERED ELIGIBLE EMPLOYEES. PART-TIME EMPLOYEES MUST WORK A MINIMUM OF 20 HOURS PER WEEK TO BE ELIGIBLE FOR HEALTH COVERAGE. PART-TIME EMPLOYEES MUST EARN A MINIMUM OF 35% OF THE YMPE FOR 24 MONTHS TO BE ELIGIBLE FOR PENSION. IF YOU ARE A TERM EMPLOYEE, YOU MAY QUALIFY FOR COVERAGE AND SHOULD CHECK WITH YOUR EMPLOYER. CASUAL STAFF, RELIEF WORKERS AND SEASONAL EMPLOYEES DO NOT QUALIFY FOR COVERAGE.

# PLEASE PRINT CLEARLY IN BLUE INK AND RETURN ORIGINAL SIGNED FORM TO THE NEBS OFFICE.

EMPLOYEE INFORMATION				
_ast Name:				
First Name:				
Mailing Address:				
Community/City: Ter	ritory/Province:	Postal Code:		
Birth Date: dd / mm / yyyy SIN	:	Sex (M/F):		
Territorial / Provincial Health Care Card: Yes	No Work Phone	:		
Email:	Other Phone	:		
Employer Name:				
Complete this section if you have a spouse or common-law spouse. A spouse is the person to whom you are legally married. A common-law spouse is a person who is living with the employee in a conjugal relationship for at least one year.				
_ast Name:	First Name:			
Birth Date: dd / mm / yyyy	0 (0.6/5)			
☐ Married ☐ Common-law	Territorial / Provincial Health	n Care Card: 🗌 Yes 🔲 No		
Co-habitation Date *COMMON-LAW SPOUSE ONLY*:	dd / mr	n / yyyy		

If you have a Common-Law Spouse a "Declaration of Common-Law Spouse" form must be provided.



#### DEPENDENT CHILDREN INFORMATION

Complete this section if you have Eligible Dependent Children. If more space is required, please copy this page.

"Eligible Dependent Child" for **Health Insurance** means, any natural, adopted, stepchild or common-law child who is financially dependent on the Employee and;

- less than 21 years of age OR;
- between ages 21 and 25 who is in full-time attendance of any educational institution. Student Declaration or proof of attendance at an accredited university or other educational institution must be provided annually. OR;
- any age if suffering from a permanent mental or physical infirmity developed while otherwise eligible as a Dependent. *Health Evidence must be provided.*

"Eligible Dependent Child" for **Pension** means, any natural, adopted, stepchild or common-law child who is financially dependent on the Employee and;

- and less than 18 for Pension OR;
- between ages 18 and 25 for Pension who is in full-time attendance of any educational institution.

No person residing outside Canada will be considered as a Dependent unless the person is classified as a full-time student and normally resides in Canada. Payment for a student shall be in accordance with the province/territory of residence of the insured Employee.

Common-Law Children shall mean any children who have cohabited with the Employee for a minimum of 12 consecutive months, unless in attendance at an accredited university or similar institution and have been publicly represented as the Employee's children and supported by the Employee.

If you have an adopted child, please provide a copy of their adoption documents. If you do not have these documents, please provide a Statutory Declaration stating they are your adopted child. Please include the full name, birth date, and date of adoption.

Child's Name (Last Name, First Name)	Natural, Adopted, Common-law, Student, Disabled Dependent	Date of Birth (dd/mm/yyyy)	Health Care Card (Yes or No)	Sex (M/F)



# OPTIONAL EMPLOYEE PLAN COVERAGE

# **EXTENDED HEALTH CARE AND VISION PLAN**

If your Employer participates in this plan, you have the option to participate. You have **30 days** from your effective date to select your level of coverage. Health evidence will be required for all late applicants. If you participate in the Extended Health Care & Vision Plan, **you must participate at least one year**, you cannot reduce or remove coverage until the first anniversary of coverage effective date.

anniversary of coverage effe		st one year, you cannot reduce of remove coverage until the in
Absence of checkmark below	w will automatically be cons	sidered a waiver of Extended Health Care and Vision coverage.
Please select your coverage:	Employee Only	Family (Including Spouse and/or Children)
	Spouse Only	No Coverage
DENTAL SERVICES PLAN		
to select your level of cover	rage. Late applicants will harvices Plan, <b>you must partic</b>	option to participate. You have <b>30 days</b> from your effective date ave reduced benefits for the first 12 months of coverage. If you cipate at least one year, you cannot reduce or remove coverage.
Absence of checkmark below	w will automatically be cons	sidered a waiver of Dental coverage.
Please select your coverage:	Employee Only	Family (Including Spouse and/or Children)
	Spouse Only	No Coverage
COORDINATION OF BENEFITS		
-	NEBS Plan coverage will be penses.	nt child(ren) are covered by any other plan for Extended Health e coordinated with other plans so that your benefits do not exceed Last Name, First Name
Employer Name:		Insurance Company:
Benefits covered by plan:	Vision Care	Extended Health Care
	Dental Care	Prescription Drugs
OPTIONAL LIFE INSURANCE		
Employees may apply to pur will be mailed to you.	rchase additional life insura	nce coverage for themselves and/or their spouse. An application
•	emium costs. Coverage for	coverage to a maximum of 20 units (\$200,000). The Employee is optional insurance shall not be effective until the first day of the red.
I am interested	in finding out more about Opt	tional Life Insurance for myself.
I am interested	in finding out more about Opt	tional Life Insurance for my spouse.



#### **DEPENDENT PARENT INSURANCE**

Employees may apply to purchase life insurance coverage for a dependent parent who resides with them and is under 70 years of age. An application will be mailed to you.

Dependent Parent Insurance is available for your dependent parent(s) who are under 70 years of age, living with you and are financially dependent on you. A flat amount of \$5,000 insurance is available to qualified dependents.

The Employee is 100% responsible for the premium costs. Coverage for optional insurance shall not be effective until the first day of the month following the date that the application is approved.

A copy of the birth certificate must be provided when submitting the dependent parent optional life insurance application.

I am interested in finding out more about Dependent Parent Insurance for my Father/Father-in-Law.  Date of Birth:dd / mm / yyyy
I am interested in finding out more about Dependent Parent Insurance for my Mother/Mother-in-Law.  Date of Birth:dd / mm / yyyy

#### INSURANCE AND HEALTH BENEFITS PLAN BENEFICIARY INFORMATION

Your insurance plan will provide benefits to those you name below in the case of your death. If you do not name a beneficiary, death benefits will be paid to your estate. If more space is required, please copy this page.

I hereby name my beneficiary(ies) for Life Insurance and Accidental Death, Disease, and Dismemberment Insurance as follows in equal shares unless otherwise provided below:

Beneficiary Name (Last Name, First Name)	Relationship to Employee	% Allocate
	_	
	Total Allocation Must Equal 100%	

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#### PENSION BENEFICIARY INFORMATION

If you have a spouse, common-law spouse or eligible dependent children they are automatically your beneficiary and eligible for survivor benefits if you die. If you do not have a spouse and you have no eligible dependent children, you should designate a beneficiary for death benefits. If you do not have a spouse or eligible dependent children and you do not designate a beneficiary, death benefits will be paid to your estate.

# PENSION DESIGNATED BENEFICIARY INFORMATION

If you do not have a spouse and you have no eligible dependent children, you should designate a beneficiary for death benefits for Pension. If you have a spouse and/or eligible dependent children, you may choose to designate a beneficiary(ies). NEBS will disburse monies to your designated beneficiary(ies), if your spouse and dependent child(ren) predecease you. I hereby appoint the following beneficiary(ies) of any monies payable upon my death under The Northern Employee Benefits Services Pension Plan as follows in equal shares unless otherwise provided below:

If more space is required, please copy this page.

Beneficiary Name (Last Name, First Name)	Relationship to Employee	% Allocated
	<b>Total Allocation Must Equal 100%</b>	

PENSION TRANSFERRING SERVICE
I am a former member of the Public Service Superannuation Act (PSSA) and would like to receive a transfer estimate.
I am a former member of the Ontario Municipal Employees Retirement System (OMERS) and would like to receive a transfer estimate.



#### CERTIFICATION

NORTHERN EMPLOYEE BENEFITS SERVICES PRIVACY STATEMENT: Northern Employee Benefits Services (NEBS) is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses while conducting business.

<u>IMPORTANT:</u> The information you have submitted on this form will be used to determine future benefits. If for any reason information changes, the Information Changes Form should be completed.

I hereby apply for plan coverage and authorize the remittance to NEBS of any required contributions. I authorize NEBS and their Insurance Underwriters, or any other person or organization having any relevant information regarding me, my spouse or dependents to release and exchange any and all information necessary for the purposes of determination of plan eligibility for benefits and administration. I confirm I am authorized to act on behalf of my spouse and/or dependents for such purposes.

I authorize the use of my Social Insurance Number (SIN) for the purposes of tax reporting, identification and administration of any benefits.

I declare that the information provided is true, complete and accurate. Any copy of this authorization shall be as valid as
the original.

Employee Signature	Date	



# THIS SECTION IS TO BE COMPLETED BY THE EMPLOYER

# Please print clearly in BLUE INK

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EMPLOYER INFORM	MATION				
Employer Name:					
Contact Person:	Last	: Name, First N	ame	Email:	
EMPLOYEE INFORN	//ATION				
Employee Name:		Last Name, Fir	rst Name	Hire Date:	dd / mm / yyyy
– Position Title:				 Annual Salary:	
·					gs, subsistence allowance, housing allowance,
living allowance, or any o	ther monies paid in	addition to the Em	nployee's ordinary wag	2S.	
Please select one:					
Permaner	nt Full Time	Perman	ent Part Time(1)	Part Time Ratio(2):	
Term(3)	Term Start Da	ate: d	d / mm / yyyy	Term End Date:	dd / mm / yyyy
35% of the YMPE for (2) Part time ratio is a (3) Term employees ar	or 24 months to be or percentage of the fure e eligible if employn	eligible for Pensior ull-time rate. Exan nent conditions me	n. nple: 35 of 40 hours pe eet the same general cri	r week or 0.875 teria as permanent full-time or p	Permanent part-time Employees must earn ermanent part-time Employees. For insurance at NEBS for a decision on the eligibility of these
ENROLMENT EFFE	CTIVE DATE				
	-				established the waiting period in their he waiting period. Retroactive billing
PENSION EFFECTIVE	DATE				
The Employer has the	option to waive t	he entire waiting	g period for Pension.		
The Em	ployer requests to	waive the entir	e waiting period for t	he above noted Employee fo	r Pension.
HEALTH INSURANCE	EFFECTIVE DATE				
The Employer has the	option to waive t	he entire waiting	g period for Health b	enefits coverage.	
The Em	ployer requests to	waive the entir	e waiting period for t	he above noted Employee fo	r Health Benefits.
EMPLOYER CERTIF	ICATION				
l certify this Employo for the NEBS Group	• •				my knowledge, an eligible Employee
			Last N	ame, First Name	dd / mm / yyyy
Employer Signature (Person with Signir			Employer Name - (Person with Sign		Date
		THIS SECT	TON IS TO BE C	COMPLETED BY NEBS	
Comments:					