NORTHERN EMPLOYEE BENEFITS SERVICES
5122 53rd Street, Yellowknife NT, X1A 1V6
Ph: (867) 873-4965 Fax: (867) 873-5801

EMPLOYEE ACKNOWLEDGEMENT OF EXTENDED HEALTH & VISION AND DENTAL BENEFITS

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

Employer Name: _____

Employee Last Name: _____ Employee First Name: _____

SIN: _____ Birth Date: _____ dd / mm / yyyy

Employee Address: _____

STATEMENT

I, _____ understand that an application to participate in Extended Health & Vision and Dental benefits has been submitted by my employer, _____

(Employee's Name) (Name of Employer)

I understand that I have 30 days from the effective date to change coverage levels without penalty. Enrolment for coverage beyond 30 days will result in the following penalties:

Extended Health & Vision Care — You and/or your family will be required to submit to Medical Health Evidence subject to approval.

Dental Services — You and/or your family will have reduced benefits for the first 12 months of coverage.

EXTENDED HEALTH & VISION CARE

☐ Employee Only ☐ Family (Including Spouse & Children) ☐ Spouse Only ☐ No Coverage

DENTAL SERVICES

☐ Employee Only ☐ Family (Including Spouse & Children) ☐ Spouse Only ☐ No Coverage

COORDINATION OF BENEFITS INFORMATION

NEBS plan coverage will be coordinated with other plans so that your benefits do not exceed 100% of actual allowable expenses.

NAME OF PERSON WITH OTHER PLAN COVERAGE: _____

TYPE OF PLAN (EMPLOYER NAME): _____

NAME OF INSURANCE COMPANY: _____

BENEFITS COVERED BY OTHER PLAN: ☐ Extended Health Care ☐ Prescription Drugs ☐ Vision Care ☐ Dental Services

AUTHORIZATION

Signature of Employee **Date**

Signature of Witness **Date**