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

NEBS ENROLMENT FORM GROUP INSURANCE

ALL EMPLOYEES WHO ARE PERMANENT FULL-TIME OR PERMANENT PART-TIME EMPLOYEES WORKING A MINIMUM OF 20 HOURS PER WEEK MUST COMPLETE AND SUBMIT THIS ENROLMENT FORM WITHIN 31 DAYS OF EFFECTIVE DATE OF COVERAGE. IF THE FORM IS NOT RECEIVED WITHIN THIS TIMELINE MEDICAL UNDERWRITING WILL BE REQUIRED AND COVERAGE MAY BE DELAYED OR DENIED. IF YOU ARE A TERM EMPLOYEE YOU MAY QUALIFY FOR COVERAGE AND SHOULD CHECK WITH YOUR EMPLOYER. CASUAL STAFF, RELIEF WORKERS AND SEASONAL EMPLOYEES ARE NOT ELIGIBLE.

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

EMPLOYEE INFORMATION

Last Name: ______________________

First Name: ______________________

Mailing Address: ______________________

Community/City: ____________ Territory/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: ______________________

SPOUSAL INFORMATION

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.

Last Name: ____________ First Name: ____________

Birth Date: dd / mm / yyyy Sex (M/F): ____________

☐ Married ☐ Common-law Territorial / Provincial Health Care Card: ☐ Yes ☐ No

Co-habitation Date *COMMON-LAW SPOUSE ONLY*: dd / mm / yyyy

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

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ELIGIBLE DEPENDENT CHILDREN INFORMATION

Complete this section if you have Eligible Dependent Children.

"Eligible Dependent Child" 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 at 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.*

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)

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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.

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	% Allocated
	Total Allocation Must Equal 100%	

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, **<u>you must participate at least one year</u>**, you cannot reduce or remove coverage until the first anniversary of coverage effective date.

Absence of checkmark below will automatically be considered 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

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. Late applicants will have reduced benefits for the first 12 months of coverage. If you participate in the Dental Services Plan, **<u>you must participate at least one year</u>**, you cannot reduce or remove coverage until the first anniversary of coverage effective date.

Absence of checkmark below will automatically be considered a waiver of Dental coverage.

☐ Employee Only ☐ Family (Including Spouse and/or Children)

☐ Spouse Only ☐ No Coverage

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COORDINATION OF BENEFITS

Complete this section if you, your spouse or dependent child(ren) are covered by any other plan for Extended Health, Vision, and/or Dental Care. NEBS Plan coverage will be coordinated with other plans so that your benefits do not exceed 100% of actual allowable expenses.

Employer Name: ______________________________

Person with Plan Coverage: Last Name, First Name Insurance Company: ______________________________

Benefits Covered by Plan:

- ☐ Vision Care
- ☐ Extended Health Care
- ☐ Dental Care
- ☐ Prescription Drugs

OPTIONAL LIFE INSURANCE

Employees may apply to purchase additional life insurance coverage for themselves and/or their spouse. An application will be mailed to you.

Optional Life Insurance is available in units of $10,000 coverage to a maximum of 20 units ($200,000). 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.

☐ I am interested in finding out more about Optional Life Insurance for myself.

☐ I am interested in finding out more about Optional 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): ____________________________

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AUTHORIZATION

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.

IMPORTANT: 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 hereby 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.

Signature of Employee	Date

NORTHERN EMPLOYEE BENEFITS SERVICES

THIS SECTION IS TO BE COMPLETED BY THE EMPLOYER

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

EMPLOYER INFORMATION

Employer Name: ____________________

Contact Person: Last Name, First Name ____________________ Email: ____________________

EMPLOYEE INFORMATION

Employee Name: Last Name, First Name ____________________ Hire Date: dd / mm / yyyy

Position Title: ____________________ Annual Salary: ____________________

Salary shall mean the Employee's regular annual salary paid by the Employer, not including bonuses, overtime earnings, subsistence allowance, housing allowance, living allowance, or any other monies paid in addition to the Employee's ordinary wages.

Please select one:

☐ Permanent Full Time

☐ Permanent Part Time Part Time Ratio: ____________________

Permanent part-time Employees must work a minimum of 20 hours per week to be eligible for health benefits
Part time ratio is a percentage of the full-time rate. Example: 35 of 40 hours per week or 0.875

☐ Term Term Start Date: dd / mm / yyyy Term End Date: dd / mm / yyyy

Term employees are eligible if employment conditions meet the same general criteria as permanent full-time or permanent part-time Employees. For insurance and health benefits and pension plan eligibility, employment must be for a minimum term and you should contact NEBS for a decision on the eligibility of these Employees.

ENROLMENT EFFECTIVE DATE

NEBS will automatically enrol the Employee after the waiting period has passed. **The completion of this section is only required if you want to waive the waiting period.** Retroactive billing may apply.

☐ The Employer requests to waive the entire waiting period for the above noted Employee.

EMPLOYER CERTIFICATION

I certify this Employee is employed under the conditions detailed above and is, to the best of my knowledge, an eligible Employee for the NEBS Health Insurance and Benefits Plan.

Employer Signature (Person with Signing Authority)	Last Name, First Name Employer Name – Print (Person with Signing Authority)	dd / mm / yyyy Date

THIS SECTION IS TO BE COMPLETED BY NEBS

Comments: ____________________

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