TRIO, PO Box 14225 (Manuels),
CBS, NL, A1W 3J1

# *Benefit Enrollment Form*

trio Life·Health·Pension

**1. TO BE COMPLETED BY EMPLOYEE (PLEASE PRINT)** **AND MAIL TO MARY GALWAY AT THE ABOVE ADDRESS OR FAX TO 1.888.584.6789**

**Member/Employee** **SIN**

**Municipality** _____ **Division** _____

**Date of Birth** DAY MON YR **Gender:** ◯ Male ◯ Female

| | Birth Date Day Mon Yr | Sex M/F | Children Status if over age 21 S = Student D = Disabled |
|---|---|---|---|
| Spouse | | | |
| Dependent Children _____ | | | |
| _____ | | | |
| _____ | | | |

**Member/Employee Address**

Street: _____

City or Town: _____

Province: _____

Postal Code: _____

Telephone #:

**2. BENEFITS**

A. ☐ **Dental:** ☐ **Single** ☐ **Family**
B. ☐ **Health:** ☐ **Single** ☐ **Family**
C. ☐ **Optional Benefits**

**Optional Benefits:**
Critical Illness: Pre-approved
☐ Member: $30,000 ☐ Spouse: $30,000 ☐ Children: $20,000 each
☐ Smoker ☐ Non-smoker ☐ Smoker ☐ Non-smoker

**3. WAIVER OF BENEFITS**

Your ability to waive benefits is governed by the Group Benefits Plan

**I DO NOT** require ☐ **Health** ☐ **Dental** as I am currently covered through my spouse's plan, or an alternative plan as indicated below. I understand that to enrol at a later date I may have to provide evidence of insurability.

Employer _____ Insurance Company _____

**X Signature of Insured** _____ **Date** ____/____/____ DAY MON YR

**4. CO-ORDINATION OF BENEFITS**

With Co-ordination of Benefits, you may be able to obtain reimbursement up to 100% of your eligible expenses. Please indicate coverage level (single/couple/family), your spouse/dependent has with another insurance provider

Name of Family Member: _____ Insurance Company: _____

☐ **Health:** ◯ **Single** ◯ **Couple** ◯ **Family** Policy Number: _____

☐ **Dental :** ◯ **Single** ◯ **Couple** ◯ **Family**

**5. BENEFICIARY DESIGNATION**

Applies to Basic Life, Basic AD&D as well as any Optional Life and Optional AD&D, unless otherwise stated

I name the following Beneficiary and reserve the right to change or cancel this at a later date

If Beneficiary is under 18, please name Trustee

Date of Birth DAY MON YR

In the event that my Beneficiary predeceases me, the following Contingent Beneficiary shall be entitled to the benefits:

Name: _____ Date of Birth DAY MON YR

**X Signature of Insured** _____ **Date** ____/____/____ DAY MON YR

**6.** I hereby apply for benefits under my Employer's plan and authorize any required payroll deductions. I consent to the use of my Social Insurance Number by any insurer or administrator for record keeping, file identification, and/or reporting purposes.

**X Signature of Insured** _____ **Date** ____/____/____ DAY MON YR

Do you wish to apply for OPTIONAL (employee-paid) life insurance? ◯ YES ◯ NO If Yes: ☐ For self ☐ For spouse

Do you wish to apply for OPTIONAL (employee-paid) Accidental Death and Dismemberment insurance? ◯ YES ◯ NO If Yes: ☐ For self ☐ For spouse

IF YOU HAVE INDICATED "YES" YOU WILL BE CONTACTED BY THE PLAN ADMINISTRATOR WITH FURTHER INFORMATION

**7. TO BE COMPLETED BY EMPLOYER (PLEASE PRINT)**

☐ Full-time Permanent ☐ Part-time Permanent ☐ Seasonal ☐ Elected Members ☐ Early Retiree ☐ Retiree Over 65

Annual Earnings: $_____ Earnings per: ☐ Hour $_____ ☐ Week $_____ ☐ Month $_____

**Date of Hire** ____/____/____ DAY MON YR

**Effective Date of Coverage** ____/____/____ DAY MON YR