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

Small Town Plan
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 _____
First Name(s) Last Name

Municipality _____ Division _____

Date of Birth ____ ____ ____ Gender ☐ Male, ☐ Female
DAY MON YR

		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/town _____

Province _____

Postal Code _____

Telephone # (____)_____

2. BENEFITS

A. ☐ Health: ☐ Single ☐ Couple ☐ Family

B. ☐ Dental: ☐ Single ☐ Couple ☐ Family

C. ☐ Optional Benefits (Please consult your Employer or Plan Administrator for information on Optional Benefits)

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, 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

_____ _____ Date of Birth ____ ____ ____
First Name(s) Last Name Relationship DAY MON YR

If Beneficiary is under 18, please name Trustee. _____
First Name(s) Last Name

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. For our full privacy statement please visit www.johnson.ca

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

7. TO BE COMPLETED BY EMPLOYER (PLEASE PRINT)

☐ Full-time Permanent ☐ Part-time Permanent ☐ Elected Members

☐ Annual Earnings:$ _____ Earnings per: ☐ Hour $_____ ☐ W eek $_____ ☐ Month $_____

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