



Enrollment/Change Form

Section 1 Employee Information

Please print clearly

Name of Employer		Client No.	
Employer's Address		Class/Sort Group	
Name of Employee		Identification No.	
Date of Birth (yyyy/mm/dd)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Occupation	
Date of Employment (yyyy/mm/dd)	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	Annual Earnings	Number of Hours Worked per Week

Section 2 Dependent Information

Name of Spouse		Date of Birth (yyyy/mm/dd)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship
If common law, please provide date of cohabitation (yyyy/mm/dd)				
Request to Co-ordinate or Waive Benefits	Co-ordinate Waive	<input type="checkbox"/> Health <input type="checkbox"/> Dental	Name of Spouse's Insurance Provider	
			Policy No.	
Name of Dependent		Date of Birth (yyyy/mm/dd)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Full time student <input type="checkbox"/> Yes Disabled dependent <input type="checkbox"/> Yes
Name of Dependent		Date of Birth (yyyy/mm/dd)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Full time student <input type="checkbox"/> Yes Disabled dependent <input type="checkbox"/> Yes

Section 3 Change Request

Nature of Change	<input type="checkbox"/> Termination <input type="checkbox"/> Layoff	<input type="checkbox"/> Reinstatement <input type="checkbox"/> Beneficiary	<input type="checkbox"/> Salary: \$ <input type="checkbox"/> Dependent Status *	<input type="checkbox"/> Other:	Effective Date
*Dependent Status Change	<input type="checkbox"/> Single <input type="checkbox"/> Family	<input type="checkbox"/> Marriage <input type="checkbox"/> Birth	<input type="checkbox"/> Common Law Status (please provide date cohabitation commenced) <input type="checkbox"/> Other:		

Section 4 Beneficiary Designation

1. Unless otherwise stipulated and unless prohibited by law, the designation of any beneficiary is revocable.
2. This designation, as authorized by the employee signature and the date below, supercedes any prior beneficiary designation.
3. If any named beneficiary is a minor (under the age of majority) you may want to name a trustee to receive the proceeds in trust for the minor until he/she attains the age majority. Any appointed trustee will remain valid once the beneficiary reaches the age of majority unless a trustee expiration date is provided below.
4. If more than one beneficiary is designated, in the absence of an employee assigned percentage, the benefit will be split equally among each named beneficiary.

Beneficiary's Full Name	Relationship	Percentage of Benefit Assigned	Trustee Assigned <input type="checkbox"/> Yes <input type="checkbox"/> No
Beneficiary's Full Name	Relationship	Percentage of Benefit Assigned	Trustee Assigned <input type="checkbox"/> Yes <input type="checkbox"/> No
Trustee Assignment (recommended if beneficiary is under the age of majority)		Expiry Date of Trustee Appointment (yyyy/mm/dd)	

Section 5 Authorization and Declaration

EMPLOYEE

I hereby apply to enroll in the group benefits program for which I am, or may become, eligible and I agree to be bound by these terms and conditions. I understand that my claims may be denied and/or benefits terminated if I provide false, incomplete or misleading information. I understand that on the date my insurance becomes effective that I must be actively at work.

I authorize ENCON and its insurers to collect, use, disclose, maintain and exchange my information with the understanding that my information will be used solely for the purposes of administration, management of my group benefits plan and adjudication of claims. Access to my information shall be limited to ENCON, its insurers, service providers or persons authorized access by law. This consent shall continue so long as myself and my dependents are covered by, or are claiming benefits under the present group contract or any modification, renewal or reinstatement thereof. I authorize the use of my Social Insurance Number as my employee number for the purpose of identification under this group policy. I understand that my claims may be denied and/or benefits terminated if I provide false, incomplete or misleading information. I acknowledge that specific details of ENCON's Privacy Policy can be found at www.encon.ca.

I authorize my employer to deduct from my pay and remit my plan member as required under the plan, if applicable.

I agree that a photocopy or electronic copy of the Authorization and Declaration section is as valid as the original. If applying for coverage for my spouse and/or dependents, I confirm that I am authorized to act on their behalf. I certify that the information given is true, correct and complete to the best of my knowledge.

Employee Signature	Date (yyyy/mm/dd)
EMPLOYER The undersigned, on behalf of the above-noted company, hereby certifies that, to the extent that available records and information permit, the statements on this form are true and complete and no material information has been omitted or withheld.	
Employer Signature	Date (yyyy/mm/dd)

This plan is sponsored by the Interior Logging Association, insured by Great-West Life and ACE INA, administered by ENCON Group Inc and arranged by Mercer (Canada) Limited.