CoRe GROUP BENEFITS

APPLICATION FOR GROUP COVERAGE
(ONTARIO DIVISION)

Please print clearly and complete both sides of this form, in INK. Section 1 is to be completed by the plan administrator and ***sections 2 through 6 are to be completed by the employee (plan member).***

1. Plan Sponsor Section

This section is to be completed by the **plan administrator**.

(Section 1 is for office use only and is to be completed by the plan administrator)

Plan Sponsor: ____________________ Employee (plan member) ID Number: __________

Service Area: ____________________ Occupation: ______________________________

Plan Name: ___________________________ Dental Plan Number: _________________

Effective date of employment: Month ___________ Day __________ Year ____________

Eligible date of coverage: Month ___________ Day __________ Year ____________

2. Employee (plan member) Information

This section is to be completed by the employee (plan member).

Please print clearly, in INK.

EMPLOYER: ____________________________ EMPLOYEE NUMBER: ___________

Employee (plan member) name: ____
last name first name middle initial

Gender: ○ Male ○ Female Date of birth: Month _______ Day ______ Year ______

Employee (plan member) ***mailing*** address:

Box # **or** Street address: ______________________________ City: __________________

Province: _______ Postal Code: ________________ Phone: _______________________

Email: ____________________________________
(MANDATORY)

Do you have a spouse (married, common-law or civil union spouse)? ○ Y ○ N

Do you have dependent children, including post sec students or disabled adults? ○ Y ○ N

How many dependents in total, including spouse? _______________________________

3. Co-ordination of Benefits

This section is to be completed by the employee (plan member).

Does your spouse have health care coverage under his/her own insurance plan? ○ Y ○ N
If yes,
Spousal insurer's name: __________________________ Plan number: _______________

If you lose spousal coverage you must notify CoRe Group Benefits of this change immediately by way of completing a **Group Coverage Change Form**. These forms can be obtained from your plan administrator or by calling CoRe BENEFITS at 1-250-378-9872.

Continued on reverse side →

4. Dependent Information

Please print clearly, in INK.

Spouse Information **(please circle: married / common-law/)**

last name ______ first name ______ middle initial ______

Date of birth ______ month ______ day ______ year ______

Gender ○ Male ○ Female

What group benefits coverage does your spouse have through his/her employer?

HEALTHCARE			DENTAL CARE			VISION CARE		
Single	Family	None	Single	Family	None	Single	Family	None
○	○	○	○	○	○	○	○	○

Where applicable, benefit payments will be coordinated between this plan and your spouse's plan.

Dependent Information

If there are more than four dependents, please attach a separate list.
IF the dependent's name is the **same as** the parent's name, please note the dependent as "Jr."

Name (last name / first name / middle initial)	Date of birth	Gender M	Gender F	Post sec student Yes	Disabled dependent Yes
last name / first name / middle initial	month/day/year	○	○	○	○
last name / first name / middle initial	month/day/year	○	○	○	○
last name / first name / middle initial	month/day/year	○	○	○	○
last name / first name / middle initial	month/day/year	○	○	○	○

5. Privacy

This section explains CoRe Benefits commitment to privacy

Protecting Your Personal Information

CoRe Benefits recognizes and respects the importance of privacy. When you apply for coverage, we establish a confidential file that is kept in a locked office within a locked filing cabinet. We limit access to personal information in your file to the Benefit Coordinator, to persons to whom you have granted access, and to persons authorized by law. We use the personal information to determine your eligibility for coverage and to administer the group benefits plan.

6. Authorizations and Declarations

This section must be **signed** and **dated** in INK by the employee (plan member).

Authorizations and Declarations
I hereby apply for coverage under the group benefits plan issued by CoRe Benefits.
I authorize:

CoRe Benefits, any healthcare provider, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with the employer to exchange personal information, when necessary to determine my eligibility for coverage and to administer the plan.
If applying for coverage for my spouse and/or dependents, I confirm that I am authorized to act on their behalf. I agree that a photocopy or electronic copy of this Authorizations and Declarations section is as valid as the original.

I certify that the information given is true, correct and complete to the best of my knowledge.

PLEASE SIGN HERE → **EMPLOYEE SIGNATURE:** ______________ Date**:** ______________