

Return to: J&D Benefits Inc. 8901 Woodbine Ave., Suite 228 Markham, ON L3R 9Y4

TEL: 1-800-218-7018, FAX: 905-477-2249

GROUP BENEFITS ENROLMENT FORM

Member Name	First		Midd	le Init.		Last					Union ID	#		
	Marital status	☐ Single	Common Law Married/Civil Union				1.	If common law, date cohabitation started:			м 	D	YYYY	
SECTION 1 SPOUSE	F	First Name	Middle Init. Last Name					Spouse Date of Birth M D YYYY				Sex Female Male		
INFORMATION		use does ne tended hea dental cove	alth	My spouse has the following benefits:				Extended Health: Dental:			☐ Single ☐ Family ☐ Single ☐ Family			
				Spouse group po number			licy Spouse ID#			Spouse insurance company			Spouse employer	
										ren age 21 or ease specify:				
	First N	lame	Last Name (only if different from employee)		lovee)	Middle Initial Se		Sex	Date of Birth				Full time student	Disabled Dependent
	Child							☐ Female	e M	D	YYYY	Yes	; 	Yes 🗆
								☐ Male				Na	me of Scho	ool and ID#
SECTION 2	Child							☐ Female	e M	D	YYYY	Yes	. 🗆	Yes 🗌
SECTION 2								☐ Male		1,		_		
DEPENDENT	Child								M	 D	YYYY			ool and ID#
INFORMATION	Criliu							☐ Female	е		1	Yes		Yes 🗆
Please list all dependents.												Na	me of Scho	ool and ID#
·	Child							☐ Female	e M	D	YYYY	Yes	; 	Yes 🗌
								☐ Male			1,,,	<u> </u>		1 1 10#
	Child								M	 D	YYYY	_		ool and ID#
	Child							☐ Female	e ivi			Yes		Yes 🗌
								_ ividio				Na	me of Scho	ool and ID#
	Child							☐ Female	e M	P	YYYY	Yes	: 🗆	Yes 🗌
								☐ Male				Na	me of Scho	ool and ID#

If you have additional dependents please list them on a separate sheet and attach to this form.

Member Name	First	Middle Init.	Last	Union ID #
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SECTION 3	I certify that I and through:	all my eligible dependents	s have coverage unde	r the British Columbia Medical Services Plan
British Columbia M.S.P. Opt Out	A.	an individual plan other employer/plan spon ne name of the plan spons		der
Complete this section only if you are already covered for MSP and are not completing the Health Insurance BC	I understand that unless applied fo		is benefit under the Mo	otion Picture Workers Health Benefits Plan
Application for Group	Signature		Date	

SECTION 4

Member
Authorization
& Company
Declaration

This section MUST be signed and dated in INK by the plan member I HEREBY APPLY for the benefits which I am or may become eligible for, subject to any waiver indicated, under my Policyholder's group insurance plan and CONFIRM that the information contained in this form is true and complete to the best of my knowledge.

If applying for benefits for my dependents, I CONFIRM THAT I AM AUTHORIZED to disclose information concerning them for the purpose of determining their eligibility for coverage.

On behalf of myself and my dependents, I CONSENT TO THE RELEASE of the information contained in this form to my Policyholder and J&D Benefits Inc., its employees, and the insurer(s) of the group insurance plan, their reinsurers and their service providers for the purpose of administration, claims processing and the enrolment of myself and my dependents in my Policyholder's group insurance plan.

I AGREE that a photocopy of this Confirmation/Authorization shall be as valid as the original.

At J&D Benefits Inc., the personal information we collect concerning you and your dependents is kept in strict confidence and used only for the purposes you have authorized. Your personal file will be kept at J&D Benefits Inc.'s offices. You have the right to request access to your personal information and, if necessary, correct any inaccurate information and/or make changes to current information whenever necessary. In order to do so, send a written request to J&D Benefits Inc., 8901 Woodbine Avenue, Suite 228, Markham, ON, L3R 9Y4.

Access to your personal information will be limited to J&D's employees and providers in the performance of their jobs, individuals to whom you have consented access, and persons authorized by law. For the purposes of audits and administrative reporting, J&D may release your Policyholder statistical financial information without personal identifiers.

Member Signature:	Date Signed: