



IATSE 891 | ACTIVE HEALTH PLAN

Return to:
J&D Benefits Inc.

8901 Woodbine Ave., Suite 228

Markham, ON L3R 9Y4

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

Email: benefitsoffilm@jdbenefits.com

GROUP BENEFITS ENROLMENT FORM

Member Name <small>First Middle Init. Last</small>	Union ID #
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SECTION 1 SPOUSE INFORMATION	Marital status	<input type="checkbox"/> Single <input type="checkbox"/> Common Law <input type="checkbox"/> Married/Civil Union <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	If common law, date cohabitation started:	M	D	YYYY	
	First Name Middle Init. Last Name			Spouse Date of Birth	Sex		
	<input type="checkbox"/> My spouse does not have extended health and/or dental coverage			<input type="checkbox"/> My spouse has the following benefits:			<input type="checkbox"/> Female <input type="checkbox"/> Male
	Extended Health: <input type="checkbox"/> Single <input type="checkbox"/> Family Dental: <input type="checkbox"/> Single <input type="checkbox"/> Family		Spouse group policy number	Spouse ID#	Spouse insurance company	Spouse employer	

SECTION 2 DEPENDENT INFORMATION <i>Please list all dependents.</i>	First Name	Last Name <small>(only if different from employee)</small>	Middle Initial	Sex	Date of Birth	For children age 21 or older please specify:						
	Child			<input type="checkbox"/> Female <input type="checkbox"/> Male	M D YYYY	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; padding: 2px;">Full time student</td> <td style="width:50%; padding: 2px;">Disabled Dependent</td> </tr> <tr> <td style="padding: 2px;">Yes <input type="checkbox"/></td> <td style="padding: 2px;">Yes <input type="checkbox"/></td> </tr> <tr> <td colspan="2" style="padding: 2px;">Name of School and ID#</td> </tr> </table>	Full time student	Disabled Dependent	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Name of School and ID#	
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	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>										
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Child			<input type="checkbox"/> Female <input type="checkbox"/> Male	M D YYYY	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; padding: 2px;">Full time student</td> <td style="width:50%; padding: 2px;">Disabled Dependent</td> </tr> <tr> <td style="padding: 2px;">Yes <input type="checkbox"/></td> <td style="padding: 2px;">Yes <input type="checkbox"/></td> </tr> <tr> <td colspan="2" style="padding: 2px;">Name of School and ID#</td> </tr> </table>	Full time student	Disabled Dependent	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Name of School and ID#		
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Full time student	Disabled Dependent											
Yes <input type="checkbox"/>	Yes <input type="checkbox"/>											
Name of School and ID#												

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

SECTION 3 Member Authorization & Company Declaration	<p>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.</p> <p>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.</p> <p>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.</p> <p>I AGREE that a photocopy of this Confirmation/Authorization shall be as valid as the original.</p>
<p>This section MUST be signed and dated in INK by the plan member</p>	<p>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.</p> <p>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.</p>
Member Signature:	Date Signed: