the benefits trust

the vero health care plan

EMPLOYEE BENEFITS ENROLLMENT FORM

Part A: Employee to complete in ink

Personal Information

☐ Mr. ☐ Mrs.
☐ Ms. ☐ Miss

Last Name: _____ First Name: _____

Address: _____ Apt. # _____

City: _____ Province: _____ Postal Code: _____

Date of Birth: (Month) _____ (Day) _____ (Year) _____ S.I.N. : _____ - _____ - _____

Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Common Law Length of C/L Relationship: _____

Dependant Information

Please list all dependants. Dependants include your spouse, common-law spouse (relationship of at least one year), and/or children. Eligible dependant children are under age 21. Eligible Overage dependant children are over age 21, under age 26 and attending school full time; or mentally or physically handicapped children who depend fully upon you for support and maintenance and are over age 21. Complete an "**Overage Dependant**" form if applicable.

	Last Name	First Name		Date of Birth (Month) / (Day) / (Year)
	_____	_____	☐ M ☐ F	_____ / _____ / _____
	Child's Last Name	First Name		(Month) (Day) (Year)
1.	_____	_____	☐ M ☐ F	_____ / _____ / _____
2.	_____	_____	☐ M ☐ F	_____ / _____ / _____
3.	_____	_____	☐ M ☐ F	_____ / _____ / _____
4.	_____	_____	☐ M ☐ F	_____ / _____ / _____

Co-ordination of Benefits

Does your **spouse** have benefits coverage through his/her employer's plan? ☐ No ☐ Single ☐ Family

Revocable Beneficiary Designation

If your beneficiary is a child under age 18, you must also complete a "**Declaration Appointing Trustee**" form.

Beneficiary's Last Name	First Name	Relationship (e.g. wife, son)	(If designating a child) Age
_____	_____	_____	_____

For Quebec residents: the appointment of a spouse as Beneficiary is considered "IRREVOCABLE" unless the word "REVOCABLE" is written after the spouse's name.

Employee Authorization

I hereby apply for the benefits for which I am or may become eligible, subject to any waiver indicated, under the Participation Agreement issued by The Benefits Trust. On behalf of myself and my dependents, I authorize The Benefits Trust (including its affiliates and/or insurance partners) to exchange the information detailed in this Enrollment and any other benefit related information contained in files regarding me or my dependents, now or in the future, for the purposes of administration and/or management of the benefits plan administered by The Benefits Trust.

Employee Signature: _____ Date: (Month) _____ (Day) _____ (Year) _____

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EMPLOYEE BENEFITS ENROLLMENT FORM

Part B: Employer to complete in ink

Instructions to Employer:

1. This application **must** be completed in **INK.**
2. Before submitting this application to The Benefits Trust please ensure that it has been completed fully. An incomplete form will delay the employee's enrollment in the plan.
3. This application **must be** received by The Benefits Trust **within 31 days** of the employee becoming eligible to join the benefits plan. If the application is received after such time, the applicant will be treated as a **LATE ENTRANT** and may be required to submit evidence of insurability to be eligible for benefits coverage.

Employer Information

Name of Employer _____ Policy Number _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Employee Coverage and Eligibility Information

Employee's Occupation _____

Benefit Class _____

Annual HCSA Amount _____

Date Employed on a Full-time Basis: (Month) _____ (Day) _____ (Year) _____

Date Coverage To Begin: (Month) _____ (Day) _____ (Year) _____

Employer Comments Please note any exceptions or other comments (e.g. waive normal waiting period requirement; special terms of employment contract which could affect benefits coverage)

Employer Authorization

Authorized Signature: _____ Date: (Month) _____ (Day) _____ (Year) _____

FOR INTERNAL USE ONLY

THE VERO HEALTH CARE PLAN is administered by:

The Benefits Trust Inc.
3800 Steeles Avenue West, Suite 102W, Toronto, Ontario L4L 4G9

Phone: 416-498-7723 or 905-264-8990 Fax: 905-264-1123
Toll Free: 1-800-487-2993