HEALTH ASSOCIATION NOVA SCOTIA

Membership Application

2 Dartmouth Road, Bedford, NS, B4A 2K7
Phone (902) 832-8500 Fax (902) 832-8505
WWW.HEALTHASSOCIATION.NS.CA

ORGANIZATION INFORMATION

Name of Organization:

Legal (Incorporated) Name:

Street (courier) Address:

Postal Code:

Mailing Address (if different from above):

Phone: | Fax:

Number of Years in Business:

Website Address:

Social Media Sites (ie. Twitter, Facebook):

Total Number of Employees:

Number of Permanent Full Time Employees:

Number of Permanent Part Time Employees:

Number of Casual/Temporary Employees:

Number of Employees Enrolled in Group Benefits if Applicable:

If a unionized workforce, what is the number of unionized employees, number of collective agreements, and the name of your bargaining unit/union representation?

IDENTIFICATION OF ORGANIZATION TYPE

- ☐ Adult Residential Centre
- ☐ Contract Service Provider
- ☐ Foundation
- ☐ Group Home
- ☐ Home Care Agency
- ☐ Home for the Aged
- ☐ Home Support Agency
- ☐ Nursing Home
- ☐ Regional Rehabilitation Centre
- ☐ Residential Care Facility
- ☐ Shared Service Provider
- ☐ Other (specify) _____

NOVA SCOTIA HEALTH AUTHORITY ZONE (if applicable)

☐ Central ☐ Northern ☐ Eastern ☐ Western

PRINCIPLE FUNDING

☐ Department of Health & Wellness ☐ Department of Community Services ☐ Other

Operating Budget: $_____

OWNERSHIP INFORMATION

Ownership Category:

☐ Private/Proprietary ☐ Private/Non-Profit ☐ Public

☐ Religious Order ☐ Municipal

Name of Owning Company: _____

Address: _____

Postal Code: _____

SENIOR MANAGEMENT TEAM

Name	Title	Phone	Fax	Email

FEE-FOR-SERVICE

Please indicate below the services which you are interested in accessing on a fee-for-service or cost-recovery basis:

Cost Recovery Services		
GROUP BENEFITS SOLUTIONS	• Long Term Disability	
	• Basic Life	
	• Health	
	• Dental	
	• Optional Life, Critical Illness, and Accidental Death & Dismemberment	
	• Employee Assistance Program (EAP) through Shepell·fgi	
NOVA SCOTIA HEALTH EMPLOYEES' PENSION PLAN		
Fee-For-Service (Contract)		
CLINICAL ENGINEERING SERVICES		
LABOUR RELATIONS & COMPENSATION ANALYSIS		
FINANCIAL SERVICES		

GROUP BENEFITS INFORMATION

**(Must be completed even if you are not interested in purchasing Group Benefits Solutions at this time)*

Why are you applying to join Health Association Nova Scotia's Group Benefits Solutions at this time? (if applicable)

How many times have you changed carriers over the past five years?

Name

Signature

Position

MISSION, VISION, AND VALUES

I have read and support the Health Association's Mission Statement, Vision Statement, and Values.

Name	Title
(Administrator/CEO) Signature	Date
Name	Title
(Board Chair) Signature	Date

Membership in Health Association Nova Scotia is at the sole discretion of the Board of Directors. Failure to provide the above information may result in membership being declined.

MEMBERSHIP INFORMATION (To be completed by the Health Association)

Membership applications for Health Association Nova Scotia are approved by the Board of Directors. The Board has established a policy that sets out the criteria the Board considers when assessing the suitability of an applicant for membership.

Membership Status: ☐ Active ☐ Associate ☐ Personal

Date membership application approved: _____