HEALTH ASSOCIATION NOVA SCOTIA

APPLICATION FORM
GROUP INSURANCE BENEFITS

EMPLOYEE INFORMATION **PLEASE USE CAPITAL LETTERS AND PRINT CLEARLY**

Last Name	First Name	Middle Name	SIN
			- -

Address	City / Town	Province	Postal Code
Telephone Number ( )	Date of Birth (DD/MM/YY) / /	Gender (M/F)	

1. Are you currently employed by another Health Association Nova Scotia Employer and a member of the Health Association Benefits? ❒ No ❒ Yes
   If yes, provide Employer name:________________________
2. Were you previously a member of the NSAHO LTD plan with this Employer and were laid off within the last 24 months? ❒ No ❒ Yes
3. Were you previously enrolled in Health Association benefits but ended your earlier employment within the last 12 months? ❒ No ❒ Yes ++
   If yes, coverage will be reinstated for all eligible benefits except for Critical Illness. If you want to enroll in the Critical Illness plan please complete the section below.

FAMILY INFORMATION

If you have eligible dependents, you must complete this section to ensure they are covered under the applicable benefits including Basic Dependent Life Insurance.

ELIGIBLE SPOUSE

01 - Last name	First name	Initial
If common-law, effective date of cohabitation (DD/MM/YY) / /	Date of birth (DD/MM/YY) / /	Gender (M/F)

ELIGIBLE DEPENDENT CHILDREN

Last name	First name	Initial	Gender M/F	Date of birth DD	MM	YY	Dependent Status*
02 -							
03 -							
04 -							
05 -							

Indicate other dependent children on additional application form. * CH – Child; E - Student (college/university – **Complete Form 56 - Overage Dependent Status Form**); S - Disabled

OPTIONAL LIFE INSURANCE FOR MYSELF *(up to a principal sum of $500,000, in units of $10,000)*

❒ No coverage

❒ If applying within 60 days of hire: Evidence-free coverage of: ❒ $10,000 ❒ $20,000 ❒ $30,000 ❒ $40,000 ❒ $50,000

Plus additional coverage of: $ ________________ (Medical Questionnaire required – see over)

❒ If applying 60 days or more after date of hire: Coverage of: $ ________________ (Medical Questionnaire required after 60 days – see over)

Mandatory: Complete Declaration of Smoker Status below. Also complete the Beneficiary Designation Form.

OPTIONAL LIFE INSURANCE FOR MY SPOUSE *(up to a principal sum of $500,000, in units of $10,000)*

❒ No coverage

❒ If applying within 60 days of hire: Evidence-free coverage of: ❒ $10,000 ❒ $20,000 ❒ $30,000 ❒ $40,000 ❒ $50,000

Plus additional coverage of: $ ________________ (Medical Questionnaire required – see over)

❒ If applying 60 days or more after date of hire: Coverage of: $ ________________ (Medical Questionnaire required after 60 days – see over)

Mandatory: Complete Declaration of Smoker Status below

OPTIONAL LIFE INSURANCE FOR MY DEPENDENT CHILDREN

❒ No coverage

❒ $2,500 ❒ $5,000 ❒ $10,000 (Medical Questionnaire required after 60 days – see over)

CRITICAL ILLNESS FOR MYSELF *(up to a principal sum of $150,000, in units of $5,000)*

❒ No coverage

❒ Evidence-free coverage of: ❒ $10,000 ❒ $15,000 ❒ $20,000 ❒ $25,000 **Mandatory:** Complete Declaration of Smoker Status below

Plus additional coverage of: $________________ (Medical Questionnaire required – see over)

CRITICAL ILLNESS FOR MY SPOUSE *(up to a principal sum of $150,000, in units of $5,000)*

❒ No coverage

❒ Evidence-free coverage of: ❒ $10,000 ❒ $15,000 ❒ $20,000 ❒ $25,000 **Mandatory:** Complete Declaration of Smoker Status below

Plus additional coverage of: $________________ (Medical Questionnaire required – see over)

CRITICAL ILLNESS FOR MY DEPENDENT CHILDREN

❒ No coverage

❒ $10,000

DECLARATION OF SMOKER STATUS *(for Optional Life And Critical Illness For Yourself And Your Spouse)*

Member

Have you smoked cigarettes, cigarillos, cigars, pipes, e-cigarettes, chewing tobacco, nicotine gum or patches, or used tobacco in any other form within the last 12 months? ❒ Yes ❒ No

________________ ________________

Date Signature of Employee

Spouse

Have you smoked cigarettes, cigarillos, cigars, pipes, e-cigarettes, chewing tobacco, nicotine gum or patches, or used tobacco in any other form within the last 12 months? ❒ Yes ❒ No

________________ ________________

Date Signature of Spouse

PLEASE COMPLETE PAGE 2 ON OTHER SIDE

MEDICAL QUESTIONNAIRE

To apply for Optional Life or Critical Illness coverage, you must request a copy of the Medical Questionnaire from your Benefit Administrator for all amounts (other than evidence-free coverage). **Coverage takes effect once the Medical Questionnaire has been approved.**

Optional Life coverage is available evidence-free only if:
- You are a new hire and are applying for coverage up to $50,000 for yourself or for your spouse within 60 days of hire
- You have a new spouse and are applying for coverage for your spouse within 60 days of marriage or one year of cohabitation
- You are enrolling your first eligible dependent child within 60 days of your child's birth, adoption or eligibility

Critical Illness is available evidence-free only if you are applying for up to $25,000 of Critical Illness coverage for yourself and/or your spouse.

OPTIONAL ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE *(up to a principal sum of $300,000, in units of $10,000)*

❒ No coverage

❒ Coverage for myself only $ ______________________ ❒ Coverage for me and my family $ ______________________

Mandatory: Complete the Beneficiary Designation Form if you are applying for coverage for the first time (or to change your beneficiary).

HEALTH **

❒ Single coverage ❒ Family coverage

❒ No coverage because I am covered under my spouse's health plan ❒ No coverage even though I am not covered elsewhere

IMPORTANT NOTES:

Premiums are required from your effective date, which is the first of the month following your date of eligibility.

If you apply for coverage more than 60 days after becoming eligible, you will need to provide evidence of insurability as outlined in the group insurance contract. Any family members who apply for coverage after 60 days of becoming eligible will also need to provide such evidence. Coverage becomes effective only once the evidence of insurability has been approved.

If you initially opt out because you are covered under your spouse's health plan, you do not have to submit evidence of insurability to join at a later date, provided you re-enrol within 60 days after losing coverage under your spouse's plan.

DENTAL **

Before you apply, please verify with your facility Benefits Administrator to make sure you are eligible for such coverage. Coverage is mandatory if you are eligible to join.

❒ Single coverage ❒ Family coverage

❒ No coverage because I am covered under my spouse's dental plan (*Please complete Health and/or Dental Coverage Elsewhere section*)

IMPORTANT NOTES: Premiums are required from your effective date, which is the first of the month following your date of eligibility.

Benefits will be limited to $125 per person for the first year of membership if:
- You opt out and re-apply for coverage after 60 days following the loss of coverage under your spouse's plan
- You move from single to family coverage but apply for such coverage after the first 60 days of acquiring your eligible dependent (in this case, the $125 limit will apply to your dependents)

** HEALTH AND/OR DENTAL COVERAGE ELSEWHERE

(If you have coverage under more than one Plan, you may be able to coordinate benefits between Plans)

Do you or any of your dependents have coverage under any other Insurer?

❒ No ❒ Yes Please indicate coverage: ❒ Health & Dental ❒ Health Only ❒ Dental Only

Name of the alternate insurer: ______________________

Identification number: ______________________ Policy number: ______________________

DECLARATION AND AUTHORIZATION

I hereby consent to the information provided in this form being collected, used or disclosed by Health Association Nova Scotia and/or any of its agents and service providers, including but not limited to insurers, benefits providers or administrators, benefits consultants and medical professionals, and shared between these parties for purposes of assessing eligibility for benefits to which I may be entitled, adjudicating any claims, auditing/reviewing the benefit plan as necessary for the proper and efficient design and administration of the plan, assessing, developing and administering related programs, and maintaining an effective claims management process. If applying for benefits for my spouse and/or dependents, I certify that I am authorized to release information concerning my spouse and/or dependents, for the purposes of determining their eligibility for benefits and any of the uses set out above. I authorize my employer(s) to notify Health Association Nova Scotia for purposes of initiating a claim for benefits or services that may be available to me or on my behalf under the plan.

I have verified the information on this form and declare that it is accurate and complete. I authorize the use of my social insurance number for group insurance identification purposes and as required by law for income tax reporting.

______________________ ______________________

Date (DD/MM/YY) Signature of Employee

Please forward the original to your Employer (Human Resources or Group Benefits Solutions Department)

TO BE COMPLETED BY EMPLOYER ONLY

Division name	Division number	Payroll number	Location

Date of hire (DD/MM/YY):

❒ Permanent full-time: Date (DD/MM/YY): ______________

❒ Permanent part-time : Date (DD/MM/YY): ______________

❒ Temporary: Start of term date (DD/MM/YY): ______________ End of term date (DD/MM/YY): ______________

❒ New ❒ Late applicant ❒ Other ______________	Annual Guaranteed Salary:	❒ Non-union ❒ Union Name ______________	❒ Clerical ❒ Management ❒ Nursing	❒ Professional ❒ Service ❒ Technical

We hereby certify that this person is an eligible employee actively at work and performing the functions of his/her position.

______________________ ______________________

Name of Authorized Benefits Administrator (Please Print) Date (DD/MM/YY)

____

Signature of Authorized Benefits Administrator

Please forward the original to Group Benefits Solutions, Health Association Nova Scotia, 2 Dartmouth Road, Bedford NS B4A 2K7.

Health Association Nova Scotia is a registered business name of Nova Scotia Association of Health Organizations.