



# GROUP INSURANCE BENEFITS APPLICATION FORM PERMANENT EMPLOYEE



**SECTION 1 - EMPLOYEE INFORMATION**

PLEASE PRINT CLEARLY

<b>Last Name</b>	<b>First Name</b>	<b>Middle Initial</b>	<b>SIN</b>
Address		City / Town	Province
Email	Telephone Number	Date of Birth (MM/DD/YYYY)	Sex

If you are currently employed by another Health Association Nova Scotia Employer and a member of the Health Association Benefits you may not have a waiting period and you may not be eligible for some coverage. Members previously enrolled in Health Association benefits but terminated employment within the last 12 months coverage will be reinstated for all eligible benefits except for Critical Illness. You must reapply for Critical Illness coverage. If you were previously a member of the HANS LTD plan with this Employer and were laid off within the last 24 months, coverage will be reinstated.

**SECTION 2 - FAMILY INFORMATION**

**REQUIRED FOR BASIC DEPENDENT LIFE, HEALTH, DENTAL, OPTIONAL LIFE, AD&D AND OPTIONAL CRITICAL ILLNESS**

**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:**    MARRIED    COMMON-LAW

01 - Last name	First name	Initial
If common-law, effective date of cohabitation (MM/DD/YYYY)	Date of Birth (MM/DD/YYYY)	Sex

**ELIGIBLE DEPENDENT CHILDREN**

Last name	First name	Initial	Sex	Date of Birth			Dependent Status*
				MM	DD	YYYY	
02 -							
03 -							
04 -							
05 -							

Indicate other dependent children on additional application form  
 \*C- Child – under age 21; D- Disabled Child (proof is required); S - Student – age 21 to 26 **(Complete Form 56 - Overage Dependent Status Form)**

**SECTION 3 – BASIC LIFE INSURANCE BENEFICIARY**

LAST NAME	FIRST NAME	RELATIONSHIP	DOB (MM/DD/YYYY)	Percentage
If any primary beneficiary is under age 18, please name a <b>trustee</b> :				<b>100%</b>

**CONTINGENT BENEFICIARY** - In the event of my death, the above listed beneficiaries will receive any benefits payable from the Basic Life Insurance Plan, if living. Otherwise, the following are my contingent beneficiaries.

LAST NAME	FIRST NAME:	RELATIONSHIP:	DOB (MM/DD/YYYY)	Percentage
If any contingent beneficiary is under age 18, please name a <b>trustee</b> :				<b>100%</b>

**SECTION 4 - HEALTH AND/OR DENTAL**

**\*\* HEALTH AND DENTAL COVERAGE IS MANDATORY UNLESS YOU HAVE COVERAGE ELSEWHERE (MUST HAVE PROVINCIAL HEALTH COVERAGE)**

Health: <input type="checkbox"/> Single coverage <input type="checkbox"/> Family coverage	Dental: <input type="checkbox"/> Single coverage <input type="checkbox"/> Family coverage
<input type="checkbox"/> No coverage because I am covered under my spouse's health plan **	<input type="checkbox"/> No coverage because I am covered under my spouse's dental plan **

**\*\* IF YOU ARE OPTING OUT OF HEALTH OR DENTAL COVERAGE, YOU MUST PROVIDE THE DETAILS OF YOUR OTHER PLAN BELOW:**

Name of the alternate insurer: \_\_\_\_\_

Identification number: \_\_\_\_\_      Policy number: \_\_\_\_\_

Last Name	First Name	Middle Initial	SIN

**SECTION 5 - OPTIONAL LIFE INSURANCE**

**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 eligibility: Evidence-free coverage of:  \$10,000  \$20,000  \$30,000  \$40,000  \$50,000  
 Plus additional coverage of: \$ \_\_\_\_\_ ‡ (Please complete Form B1 - Evidence of Insurability for Optional Life Insurance)

If applying after 60 days: Coverage of: \$ \_\_\_\_\_ ‡ (Please complete Form B1 - Evidence of Insurability for Optional Life Insurance)

**Mandatory: Please complete both the Declaration of Smoker Status-Section 7 and the Beneficiary Designation-Section 6.**

**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 eligibility: Evidence-free coverage of:  \$10,000  \$20,000  \$30,000  \$40,000  \$50,000  
 Plus additional coverage of: \$ \_\_\_\_\_ ‡ (Please complete Form B1 - Evidence of Insurability for Optional Life Insurance)

If applying after 60 days: Coverage of: \$ \_\_\_\_\_ ‡ (Please complete Form B1 - Evidence of Insurability for Optional Life Insurance)

**Mandatory: Please complete the Declaration of Smoker Status – Section 7**

**OPTIONAL LIFE INSURANCE FOR MY DEPENDENT CHILDREN**

No coverage  \$2,500  \$5,000  \$10,000

**SECTION 6 - OPTIONAL LIFE INSURANCE BENEFICIARY**

LAST NAME	FIRST NAME	RELATIONSHIP	DOB: (MM/DD/YYYY)	Percentage:

If any primary beneficiary is under age 18, please name a **trustee**: **100%**

**CONTINGENT BENEFICIARY** - In the event of my death, the above listed beneficiaries will receive any benefits payable from the Optional Life Insurance Plan, if living. Otherwise, the following are my contingent beneficiaries.

LAST NAME	FIRST NAME:	RELATIONSHIP:	DOB: (MM/DD/YYYY)	Percentage:

If any contingent beneficiary is under age 18, please name a **trustee**: **100%**

**SECTION 7 - DECLARATION OF SMOKER STATUS**

**COMPLETE IF YOU ARE APPLYING FOR OPTIONAL LIFE AND/OR OPTIONAL CRITICAL ILLNESS FOR YOURSELF OR YOUR SPOUSE**

**Employee**  
 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 (MM/DD/YYYY) \_\_\_\_\_  
 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 ((MM/DD/YYYY) \_\_\_\_\_  
 Signature of Spouse

‡ For additional forms visit [www.healthassociation.ns.ca](http://www.healthassociation.ns.ca)

<b>Last Name</b>	<b>First Name</b>	<b>Middle Initial</b>	<b>SIN</b>

**SECTION 8 – OPTIONAL CRITICAL ILLNESS INSURANCE**

<p><b>OPTIONAL CRITICAL ILLNESS INSURANCE FOR MYSELF</b> (up to a principal sum of \$150,000, in units of \$5,000, minimum of \$10,000)</p> <p><input type="checkbox"/> No coverage</p> <p><input type="checkbox"/> Evidence-free coverage of: <input type="checkbox"/> \$10,000   <input type="checkbox"/> \$15,000   <input type="checkbox"/> \$20,000   <input type="checkbox"/> \$25,000</p> <p>Plus additional coverage of: \$ _____ ‡ (Please complete Form 57 - Evidence of Insurability for Optional Critical Illness)</p> <p><b>Mandatory: Please complete the Declaration of Smoker Status–Section 7</b></p>
<p><b>OPTIONAL CRITICAL ILLNESS INSURANCE FOR MY SPOUSE</b> (up to a principal sum of \$150,000, in units of \$5,000, minimum of \$10,000)</p> <p><input type="checkbox"/> No coverage</p> <p><input type="checkbox"/> Evidence-free coverage of: : <input type="checkbox"/> \$10,000   <input type="checkbox"/> \$15,000   <input type="checkbox"/> \$20,000   <input type="checkbox"/> \$25,000</p> <p>Plus additional coverage of: \$ _____ ‡ (Please complete Form 57 - Evidence of Insurability for Optional Critical Illness)</p> <p><b>Mandatory: Please complete the Declaration of Smoker Status – Section 7</b></p>
<p><b>OPTIONAL CRITICAL ILLNESS INSURANCE FOR MY DEPENDENT CHILDREN</b></p> <p><input type="checkbox"/> No coverage      <input type="checkbox"/> \$10,000</p>

**SECTION 9 - OPTIONAL ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE**

<p><input type="checkbox"/> No coverage</p> <p>(UP TO A PRINCIPAL SUM OF \$500,000, IN UNITS OF \$10,000)</p> <p><input type="checkbox"/> Coverage for myself only \$ _____      <input type="checkbox"/> Coverage for me and my family \$ _____</p> <p><b>Mandatory: Complete the Beneficiary Designation – Section 10      Refer to the website for information on family coverage amounts.</b></p>
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**SECTION 10 - OPTIONAL ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE BENEFICIARY**

LAST NAME	FIRST NAME	RELATIONSHIP	DOB: (MM/DD/YYYY)	Percentage:
If any primary beneficiary is under age 18, please name a <b>trustee</b> :				<b>100%</b>
<b>CONTINGENT BENEFICIARY</b> - In the event of my death, the above listed beneficiaries will receive any benefits payable from the Optional AD&D Insurance Plan, if living. Otherwise, the following are my contingent beneficiaries:				
LAST NAME	FIRST NAME:	RELATIONSHIP:	DOB: (MM/DD/YYYY)	Percentage:
If any contingent beneficiary is under age 18, please name a <b>trustee</b> :				<b>100%</b>

**SECTION 11 – 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 (MM/DD/YYYY)      Signature of Employee

Please forward the original to your Employer.

‡ For additional forms visit [www.healthassociation.ns.ca](http://www.healthassociation.ns.ca)

Last Name	First Name	Middle Initial	SIN

TO BE COMPLETED BY EMPLOYER ONLY					
Division name		Division number	Payroll number	Location	
Date of hire (MM/DD/YYYY):	Date eligible (MM/DD/YYYY):		<input type="checkbox"/> Permanent full-time <input type="checkbox"/> Permanent part-time		
New Late applicant Proxy Temporary to Permanent Other _____	Annual Guaranteed Salary:	<input type="checkbox"/> CUPE <input type="checkbox"/> NSNU <input type="checkbox"/> NSGEU	<input type="checkbox"/> Unifor <input type="checkbox"/> Non-union <input type="checkbox"/> Other _____	Clerical Management Nursing	Professional Service Technical

NOTES:

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

Today's Date (MM/DD/YYYY)	Benefit Administrator's Name:
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**Employer - Please upload to your facility folder on our secure SharePoint site. Please do not also forward the original to Health Association Nova Scotia – Keep the original for your records.**