HEALTH ASSOCIATION NOVA SCOTIA

GROUP INSURANCE BENEFITS APPLICATION FORM LTD ONLY

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THIS FORM SHOULD BE USED FOR MEMBER ORGANIZATIONS PARTICIPATING IN THE LTD COVERAGE ONLY OR WHEN AN EMPLOYEE IS HIRED TO WORK LESS THAN 28 HOURS ON A BI-WEEKLY BASIS BUT HAS WORKED ON AVERAGE 28 HOURS BI-WEEKLY IN THE LAST CALENDAR YEAR.

SECTION 1 - EMPLOYEE INFORMATION **PLEASE PRINT CLEARLY**

Last Name	First Name	Middle Initial	SIN

Address	City / Town	Province	Postal Code

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. 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 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.

TO BE COMPLETED BY EMPLOYER ONLY

Division name	Division number	Payroll number	Location

Date of hire (MM/DD/YYYY):	Date eligible (MM/DD/YYYY):	○ Permanent full-time ○ Permanent part-time ○ Permanent part-time1 (less than 28 hours)

○ New ○ Late applicant ○ Proxy ○ Other _____	Annual Guaranteed Salary:	○ CUPE ○ Unifor ○ NSNU ○ NSGEU	○ Non-union ○ 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:

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.