HEALTH ASSOCIATION NOVA SCOTIA

GROUP INSURANCE BENEFITS APPLICATION FORM PERMANENT EMPLOYEE

ENRO

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 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 **trustee:**				**100%**

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 **trustee:**				**100%**

SECTION 4 - HEALTH AND/OR DENTAL

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

Health: ○ Single coverage ○ Family coverage

○ No coverage because I am covered under another group or association plan**

Dental: ○ Single coverage ○ Family coverage

○ No coverage because I am covered under another group or association 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**

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SECTION 8 – OPTIONAL CRITICAL ILLNESS INSURANCE

OPTIONAL CRITICAL ILLNESS INSURANCE FOR MYSELF *(up to a principal sum of $150,000, in units of $5,000, minimum of $10,000)*

○ No coverage

○ Evidence-free coverage of: ○ $10,000 ○ $15,000 ○ $20,000 ○ $25,000

Plus additional coverage of: $ _____ ‡ **(Please complete Form 57 - Evidence of Insurability for Optional Critical Illness)**

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

OPTIONAL CRITICAL ILLNESS INSURANCE FOR MY SPOUSE *(up to a principal sum of $150,000, in units of $5,000, minimum of $10,000)*

○ No coverage

○ Evidence-free coverage of: : ○ $10,000 ○ $15,000 ○ $20,000 ○ $25,000

Plus additional coverage of: $ _____ ‡ **(Please complete Form 57 - Evidence of Insurability for Optional Critical Illness)**

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

OPTIONAL CRITICAL ILLNESS INSURANCE FOR MY DEPENDENT CHILDREN

○ No coverage ○ $10,000

SECTION 9 - OPTIONAL ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

○ No coverage

(UP TO A PRINCIPAL SUM OF $500,000, IN UNITS OF $10,000)

○ Coverage for myself only $ _____ ○ Coverage for me and my family $ _____

Mandatory: Complete the Beneficiary Designation – Section 10 **Refer to the website for information on family coverage amounts.**

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 **trustee:**				**100%**

CONTINGENT BENEFICIARY - 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 **trustee:**				**100%**

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

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):		◯ Permanent full-time ◯ Permanent part-time		
◯ New ◯ Late applicant ◯ Proxy ◯ Temporary to Permanent ◯ Other _____	Annual Guaranteed Salary:	◯ CUPE ◯ Unifor ◯ NSNU ◯ Non-union ◯ NSGEU ◯ 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.