HEALTH ASSOCIATION NOVA SCOTIA

GROUP INSURANCE BENEFITS APPLICATION FORM TEMPORARY 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.

SECTION 2 - FAMILY INFORMATION

REQUIRED FOR BASIC DEPENDENT LIFE, HEALTH & DENTAL

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 MM	Date of Birth DD	Date of Birth YYYY	Dependent Status*
02 -							
03 -							
04 -							
05 -							
06 -							

Indicate other dependent children on additional application form
*C- Child – under age 21; D- Disabled Child (proof 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%**

‡ **For additional forms visit www.healthassociation.ns.ca**

Last Name	First Name	Middle Initial	SIN

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: _____

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):	Start of term date (MM/DD/YYYY):	End of term date (MM/DD/YYYY):

◯ New ◯ Late applicant ◯ Proxy ◯ Other _____	Annual Guaranteed Salary:	◯ CUPE ◯ NSNU ◯ NSGEU ◯ Non-union ◯ Other _____	◯ Clerical ◯ Management ◯ Nursing ◯ Professional ◯ Service ◯ Technical

Employer 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.