MATRIX ENROLLMENT OR CHANGE FORM

ID #

NOTIFICATION

☐ New ☐ Reinstatement ☐ Benefit Change

☐ Add Dependent ☐ Delete Dependent ☐ Other Change _____

Effective Date:_____

EMPLOYER DATA (Please type or print clearly in ink)

If enrollment is not made on time, coverage may be limited or denied based on proof of insurability.

Employer_____ Policy #_____ Div._____ Class_____

Full-time Hire Date _____ mm _____ dd _____ yy

Hours worked (per week)_____

Description of Occupation_____

Part-time Hire Date _____ mm _____ dd _____ yy

Earnings $_____ ☐ Annually ☐ Bi-Weekly ☐ Hourly ☐ Monthly

Waive Waiting Period ☐ Yes ☐ No If yes, reason for waiving: _____

Employer's Signature_____ Position_____ Date_____

EMPLOYEE STATEMENT

Employee's Surname_____ First Name_____

Address_____ City_____ Prov._____ Postal Code_____

Sex ☐ F ☐ M Date of Birth _____ mm _____ dd _____ yy Email Address_____

Marital Status ☐ Single ☐ Married ☐ Common-Law* *Indicate date of cohabitation _____ mm _____ dd _____ yy

BENEFIT SELECTION – EXTENDED HEALTH AND DENTAL

Confirmation of Provincial Health Coverage

☐ Yes, myself and my dependent(s) are covered under the provincial health plan.

☐ No, myself and/or my dependent(s) are not covered under the provincial health plan.

Please indicate effective date of provincial health coverage _____ mm _____ dd _____ yy

☐ **Single,** Extended Health Care
☐ **Single,** Dental

☐ **Family,** Extended Health Care
☐ **Family,** Dental

☐ **Waive,** Extended Health Care*
☐ **Waive,** Dental*

Please indicate if you have coverage through your spouse E.H.C. ☐ Yes ☐ No Dental ☐ Yes ☐ No

Spouse's Group Insurance Carrier_____

**I understand that I can join the Health/Dental plan if I apply within 31 days of the termination of my spouse's/partner's coverage with his/her Employer. If I apply more than 31 days after the termination of my spouse's/partner's coverage, evidence of insurability will be required, and Dental coverage will be restricted. If I and/or my dependents have no current Group coverage, I understand I/we can apply in the future only with satisfactory evidence of insurability and coverage may be restricted or denied.*

Matrix Benefit Services Tel: (905) 426-8850 Outside Toronto: 1-800-265-4455 Fax: (905) 426-9844

ID #

DEPENDENT INFORMATION

Surname	First Name	M/F	Date of Birth mm/dd/yy			Student* *Check box*	Disabled** *Check box*
Spouse							
Children						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐

*Students over 21 and under 25 are only eligible if they submit proof of full-time registration.
**Disabled dependents over 21 may be eligible for coverage if certain conditions are met.

BENEFICIARY INFORMATION

Primary Beneficiary(ies) (*in equal shares unless other percentage indicated):*

Full Legal Name_____ Relationship to Employee_____ % Share_____

Full Legal Name_____ Relationship to Employee_____ % Share_____

Full Legal Name_____ Relationship to Employee_____ % Share_____

Contingent Beneficiary(ies) (*in equal shares unless other percentage indicated):*

Full Legal Name_____ Relationship to Employee_____ % Share_____

Full Legal Name_____ Relationship to Employee_____ % Share_____

Full Legal Name_____ Relationship to Employee_____ % Share_____

If the Beneficiary(ies) is/are under the age of majority at the time of the insured's death, proceeds of the policy shall be payable to the following Trustee:

Full Legal Name_____ Relationship of Trustee to Plan Member_____

Quebec residents only: Designating your spouse as beneficiary is irrevocable unless you make the designation revocable. An irrevocable beneficiary designation cannot be changed without the written consent of the irrevocable beneficiary. A revocable beneficiary designation can be changed at any time without the consent of the revocable beneficiary.

I elect to make my spouse (married or civil union) designation: ☐ Revocable

AUTHORIZATION

I hereby authorize my employer, group plan administrator, insurer or their agents, or any other person or organization having any relevant information regarding me, my spouse or dependents to release and exchange any and all information necessary for the purposes of determination of eligibility for benefits and administration of the group benefits plan. I confirm I am authorized to act on behalf of my spouse and/or dependents for such purposes.

I declare that the information provided is true, complete and accurate. Any copy of this authorization shall be as valid as the original.

I designate the beneficiary(ies) stated above.

Employee Signature_____ Date_____

Matrix Benefit Services Tel: (905) 426-8850 Outside Toronto: 1-800-265-4455 Fax: (905) 426-9844