



GROUP ENROLLMENT FORM

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TO PROCESS YOUR ENROLLMENT, ALL APPLICABLE FIELDS ON THIS FORM MUST BE COMPLETED

PART A - Employee/Retiree Contact Information

First Name: _____ Last Name: _____
Middle Initial: _____ Date Of Birth (MM/DD/YYYY): _____ Gender: ☐ Female ☐ Male
Street Address: _____
Apt: _____ City: _____ Province: _____ Postal Code: _____
Phone: _____ Email Address: _____
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Common Law*
I am covered under a provincial Health Plan (i.e. OHIP card): ☐ Yes ☐ No (See page 2)

PART B - Employment Details

For Employees Only (Current Position)

☐ Part-Time ☐ Casual ☐ Contract ☐ Temporary Date Hired (MM/DD/YYYY): _____
Occupation: _____ Gross Monthly Salary: _____ Average Weekly Hours: _____
Are you currently on maternity, disability or any other kind of leave? ☐ Yes ☐ No
Are you on hospital payroll? ☐ Yes ☐ No Hospital: _____

For Retirees Only

☐ Retired From Hospital Date Retired (MM/DD/YYYY): _____ Hospital: _____
Last Day Actively Worked At The Hospital (MM/DD/YYYY): _____
Did you retire while on a disability or any other kind of leave? ☐ Yes ☐ No
Are you currently collecting ANY long term disability benefits? ☐ Yes ☐ No

PART C - Enrollment Information For Dependants

Any dependants (including spouse) eligible for coverage must be listed below. Student refers to full-time post secondary enrollment of dependant children age 21-25.

Dependants:	First Name:	Last Name:	Gender: (M/F)	Date Of Birth: (MM/DD/YY)	Student: (Y/N)
Spouse:					
1 st Child:					
2 nd Child:					
3 rd Child:					

My dependants are covered under a provincial health plan (i.e. OHIP card): ☐ Yes ☐ No

PART D - Coverage Information

Select Package Level: ☐ Signature ☐ Supreme ☐ Standard
Select Health Plan: ☐ Essential ☐ Essential Plus ☐ Complete ☐ Complete Plus
Select Dental Plan: ☐ No Dental ☐ Basic Dental ☐ Enhanced Dental

☐ I wish to be considered for the Optimum level of coverage & have included a Statement of Health form (Form 2)



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PART E - Beneficiary Designation (Mandatory for Signature & Supreme Enrollees Only)

Beneficiary: _____ Relationship To Insured: _____

Trustee (Must Name A Trustee If Beneficiary Is Under 18 Years of Age): _____

PART F - Declaration For Common-Law Coverage*

I the undersigned, hereby certify that I have been living with _____ since (MM/DD/YYYY) _____ and representing him/her as my spouse or my (common-law) spouse. I further certify that I and/or my (common-law) spouse are solely responsible financially for either of our children claimed for insurance purposes. I further certify that I do not have or do not wish to provide coverage for my legal spouse, if any.

PART G - Proof of Coverage (For Signature Package Enrollees Only)

Are you currently covered under your spouse's (or another group) benefits plan? ☐ Yes ☐ No

Provided By: _____ Insured Through: _____

PART H - Payment Information (Mandatory On All Enrollments)

Deposit and first month premium are only collected by credit card OR 2 cheques. Choose one method of payment for your deposit and first month premium:

☐ Credit Card

A member of the HCP Group Insurance team will contact you to securely collect your credit card payment information. Please do not include credit card details on this form.

☐ Cheque

We require **two cheques (NOT void)** to be submitted with your enrollment and both must be made payable to **HCP Group Insurance**.

If paying deposit and first month premium by credit card, please attach a void cheque or pre-authorized debit form from your financial institution to your application. *Your account must have chequing privileges.* Alternatively, you may provide your banking details in the space below.

Institution: _____ Branch: _____ Bank Account Number: _____

I hereby authorize Health Care Providers to arrange automatic deductions from the account provided.

Dated _____ this _____ day of _____ 20 _____
(City/Town) (Day) (Month) (Year)

Signature of Employee: _____

☐ I'm retired and would like my monthly premium withdrawn on the first of the month

PART I - Enrollment Acknowledgment

I hereby enroll for the benefit coverage from Health Care Providers Group Insurance Plan™ for which I am eligible, and I authorize the hospital to release my address, phone and income information to the plan administrator if required. I acknowledge all information is complete and accurate. I understand that the health evidence provided by me and my dependants as part of this enrollment may be used by all parties involved in the issuing of my coverage and I hereby consent to such usage on my behalf of myself and any dependants for whom coverage is sought. I understand that Health Care Providers Group Insurance Plan™ reserves the right to audit claims. I understand that coverage is effective on the first of the month following the date that my enrollment is received, unless I elect to delay the effective date one month, provided all the requirements have been met:

- A fully completed, signed enrollment and required premium has been received
- Underwriting approval for instances where underwriting is required
- I continue to meet all eligibility rules

I acknowledge that it is my sole responsibility to inform Health Care Providers Group Insurance Plan™ of any changes in my work hours, status or otherwise in the event that it may affect my eligibility for coverage, and that failure to do so may result in premiums paid when coverage is not required and refunds under these circumstances will not be made.

Date (MM/DD/YYYY): _____ Signature of Employee: _____

PRIVACY: All information about the insurability of you and your dependants is considered confidential. Health Care Providers Group Insurance Plan™ is a business name registered to HMA The BENEFITS People and we are committed to protecting the privacy, confidentiality, accuracy and security of the personal information that is collected, used, retained and disclosed in the course of conducting business.

Please send all forms to: HCP Group Insurance Plan, 1032 Brock Street South, Whitby, ON L1N 4L8 or email to info@healthcareproviders.ca