Group Benefits Enrollment Form

To be completed by the plan administrator			
Employer/**COMPANY** Name		Date of Hire (mmm/dd/yyyy)	Eligible Date of Coverage (mmm/dd/yyyy)
Policy/Group #:	Division Name:	Cert #: (PBI OFFICE USE ONLY)	Employer Issued Id #: (IF APPLICABLE)
Occupation:		Annual Earnings:	Hours worked per week:
☐ Assign Healthcare Spending Account	Effective Date:		Annual Amount:

To be completed by the employee		
Employees Last & First Name	☐ Male ☐ Female	Date of Birth (mmm/dd/yyyy)
Employee **HOME MAILING** Address	Email:	
	Work Ph.	Home Ph.

Are you choosing (PLEASE CHECK ONLY ONE)	☐ Single	☐ Family	☐ Waiving Health for Dependents Only
	☐ Waiving Dental for Dependents Only		☐ Refusal/No Coverage (For your record only)

Acknowledgement and Consent

☐ I consent (named individual) _____ can, on my behalf

- Contact my benefit provider via telephone, email, and by means of any other applicable correspondence regarding my policy details.
- Access, view, and bookmark all documents, reports, statements, and coverage confirmations sent from my benefit provider.
- Access, view, reply to, archive, bookmark, and delete all messages sent from my benefit provider.
- Access, view, and change banking information through online member access.

Name of Employee (PLEASE PRINT)	Signature of Employee	Date

Dependent Information

Spouse

Last & First Name	☐ Male ☐ Female	Date of Birth (mmm/dd/yyyy)

Indicate your spouse's coverage with his/her employer					Policy #:
Health	☐ Single	☐ Family	☐ Waived	☐ None	
Dental	☐ Single	☐ Family	☐ Waived	☐ None	Insurance Provider Name:
Vision	☐ Single	☐ Family	☐ Waived	☐ None	

Dependent Children

Last & First Name	Date of Birth (mmm/dd/yyyy)	Relationship (son, daughter, etc.)	Is s/he attending full time post-secondary education?

Direct Deposit Authorization (PLEASE PRINT)					
I hereby authorize PROBENEFITS INC. to initiate a credit to my account by method of Electronic Funds Transfer					
Bank Route #		Bank Transit #		Account #	
Name of Bank:					
Bank Address:					
	STREET		CITY, PROVINCE		POSTAL CODE
Please attach a sample cheque marked **"VOID"**					

Protecting your personal information: At ProBenefits Inc., we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that is kept in the offices of ProBenefits or the offices of an organization authorized by ProBenefits. We limit access to personal information to your file to ProBenefits staff or persons authorized by ProBenefits who require it to perform their duties, to persons whom you have granted access, and to persons authorized by law. We use the personal information to determine your eligibility for coverage and to administer the group benefits plan.

Name of Employee (PLEASE PRINT)	Signature of Employee	Date

ProBenefits Inc.
employer benefit solutions

CONTACT US:

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