ProBenefits Inc.
employer benefit solutions

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Group Benefits Enrollment Form

All sections must be completed in FULL

Section 1: To be completed by the PLAN ADMINISTRATOR

EMPLOYER/COMPANY Name	Date of Hire (mmm/dd/yyyy)	Effective Date of Coverage (mmm/dd/yyyy)
Division Name:	Policy/Group #:	Cert #: (PBI OFFICE USE ONLY)
Occupation:	**Annual** Earnings:	Hours worked per week:

Please choose:	☐ Single	☐ Family	☐ Waiving Health for Dependents Only
	☐ Waiving Dental for Dependents Only		☐ Refusal/No Coverage

☐ Assign Healthcare Spending Account	Effective Date:	Annual Amount:

Section 2: To be completed by the EMPLOYEE (PLEASE PRINT CLEARLY)

Employees Last Name	First Name	
Address (street number and name)		
City	Province	Postal Code
☐ Male ☐ Female ☐ Undisclosed	Date of Birth (mmm/dd/yyyy)	Provincial Health Number
Email *REQUIRED* if no email a cell phone number is needed.	Daytime Ph.	

Section 3: Dependent Information

Spouse/Partner Information

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

Indicate your spouse's coverage with his/her employer

Health	☐ Single	☐ Family	☐ Waived	☐ None	Policy #:
Dental	☐ Single	☐ Family	☐ Waived	☐ None	Insurance Provider Name:
Vision	☐ Single	☐ Family	☐ Waived	☐ None	

Dependent Children

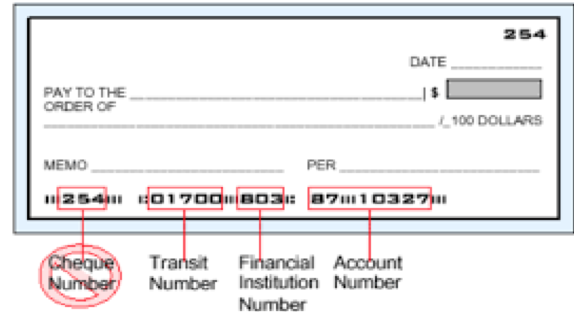
Last & First Name	Date of Birth (mmm/dd/yyyy)	Relationship (son, daughter, etc.)	Over Age Student?
1.			☐ Yes ☐ No
2.			☐ Yes ☐ No
3.			☐ Yes ☐ No
4.			☐ Yes ☐ No

If your dependent is a full-time student aged 21 or older, complete the below:

First Name	Educational Institution attending	Program(s)	Start Date (mmm/dd/yyyy)	End Date (mmm/dd/yyyy)
1.				
2.				

Section 4: Direct Deposit Authorization

I hereby authorize PROBENEFITS INC. to initiate a credit to my account by method of Electronic Funds Transfer. Your banking information can be located on your personal cheque or bank statement.



Transit Number: _______ _______ _______ _______ _______

Institution Number: _______ _______ _______

Account Number: _______ _______ _______ _______ _______ _______ _______ _______ _______ _______ _______ _______

Section 5: Acknowledgement and Consent

I authorize ____, on my behalf to:

- 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.

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