



DEPENDENT ENROLMENT FORM FOR GROUP HEALTH AND / OR DENTAL INSURANCE

Do Not Use this form for Initial Enrolment.

To be completed only if: **1. A change in dependent coverage is required.**

OR

2. If there is a group plan change adding a pay-direct drug plan and dependent coverage is required.

PLEASE NOTE: Benefit claims are adjudicated based on the details provided on this form.

Please report any changes immediately to avoid any potential claims problems.

1 POLICYHOLDER / EMPLOYEE DETAILS

Employee's Full Name (Last, First, Middle)				Certificate Number				
Company Name				Division		Policy Number		
Date of Birth:	day	month	year	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Full-Time Employment:	day	month	year

2 SPOUSE / PARTNER DETAILS (Complete this part if you require coverage for your Spouse / Partner.)

Spouse / Partner's Full Name (Last, First, Middle)				Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth	
Date of Marriage/ Common-law Relationship				day	month	year	
Are your Spouse / Partner and children, if any, covered for Health and Dental with another insurance company? <input type="checkbox"/> No <input type="checkbox"/> Yes → If yes, provide the following information to co-ordinate benefits for <input type="checkbox"/> Health and/or <input type="checkbox"/> Dental							
Name of Insurance Company				Name of Employer			

3 DEPENDENT CHILDREN DETAILS (Complete this part if you require coverage for your Dependent Children.)

Children's Full Names (First, Middle, Last)	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	* <input type="checkbox"/> Disabled or ** <input type="checkbox"/> Student
1)		day month year	
2)		day month year	
3)		day month year	
4)		day month year	
5)		day month year	
6)		day month year	

* Disabled dependents aged 21 and older may be eligible for coverage if certain conditions, as established by Equitable Life®, are met. You may be asked to provide further documentation.

** Dependent children aged 21 and older, but under age 25, (or the maximum dependent age as per the Policy) are eligible for coverage if registered as Full-Time Students. You may be asked to provide proof of full-time student status.

4 I certify that all the information provided on this form is true and agree that benefits will be co-ordinated as outlined in the Policy if applicable. (Refer to the Co-ordination of Benefits Section in your booklet for details when your spouse / partner also has a Benefit Plan with his/her employer.)

The Canadian Life & Health Insurance Association Regulations stipulate:

- A spouse / partner must submit claims to his/her own employer's plan first.
- Claims for insured children must first be submitted to the plan insuring the spouse / partner whose date of birth is the earliest in the calendar year. If both spouses / partners were born in the same Month, the earlier Day would be the rule.

Employee's Signature	Date
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THIS FORM WILL BE RETURNED IF NO SIGNATURE and DATE ARE PRESENT!