Key Points to Completing the
Group Insurance Enrollment Form

- The name of employer and employee first and last name must be completed
- Benefits can be provided if the employee is not covered by the Provincial Health Plan however the coverage for travel and hospital will not apply and the amount that may be claimed for prescription drugs may be limited. Please ensure this section is completed.
- If there are employees on Work Visas/ Permits, we will require a copy of it for our records. In addition please note that those employees will not be eligible for Short Term Disability or Long Term Disability. Please ensure this section is completed.
- Please ensure the information provided is legible to ensure the names are correct on the employee cards
- Please tick off the appropriate gender
- Please ensure the Birth Date and Province of Residence is complete. *Please note – the province of residence is the province the employee lives in not the province where the employee was born*
- Please indicate the marital status. *When marital status is common-law the date of cohabitation must be indicated. Common-law dependents are eligible after one year of cohabitation*
- Spouses and dependents must be listed. Please ensure the name, gender, birthdates and relationship to the employee (spouse, child etc.) are completed and legible. This information will appear on the cards.
- If the employee is covered under another plan the appropriate information should be indicated in the appropriate section (under the section where dependents are listed)
- You may list as many beneficiaries as you wish. If you wish to list more than two please note the list of beneficiaries on an additional form. The trustee designation is required when one or more of the beneficiaries are under the age of 18. If the employee does not wish to designate a beneficiary the designation can be completed indicating "estate"
- The date and signature next to the beneficiary is mandatory. This signature is required prior to processing of the form
- If an employee has comparable health and dental coverage through another plan they may opt to waive the coverage for themselves or for themselves and their dependents. Please ensure the appropriate boxes are checked off to get the coverage the employee wishes and the information pertaining to the other plan is indicated on the form. Please ensure the waiver section of the enrollment form is signed and dated. If the employee is waiving for their dependents only they will have single coverage. If they are waiving for themselves and their dependents they will not have health and/or dental coverage of any kind. If the employee wishes to obtain the coverage at a later date they may do so only if the other coverage terminates. If they want the coverage at a later date and the other coverage is still in force they will have to apply as a late applicant. Late applications are subject to the approval of health evidence and dental restrictions will apply.
- The bottom section is for the employer/administrator to complete. Please complete the employee's earnings, hours per week, occupation and employment date. The Payroll Number section is optional and does not require completion. The employer signature and date is required.

Group Insurance Enrollment

☐ New Employee
☐ Reinstatement

Please mail original completed form to BBD:
500-2755 Lougheed Highway Port Coquitlam, BC V3B 5Y9

Name of Employer:

▶ *PLEASE PRINT. Please submit original application only — fax copies or photocopies cannot be accepted* ◀

▶ Employee – Complete this section ◀

Employee Last Name	First Name	Initial	Are you in Canada on a Work Visa/Permit? *Copy required to enroll in plan. ☐ Yes ☐ No	Are you covered under your Provincial Health Plan? ☐ Yes ☐ No

Address	City	Province of Residence	Postal Code

Gender: ☐ Male ☐ Female

Birth Date: Month | Day | Year

Language Preference ☐ English ☐ French Email Address:_____

Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Common Law*
* Date of Cohabitation _____ (*Date of Cohabitation is mandatory if Common Law)

Dep. No.	List Dependents Last Name	First Name	Initial	Sex M/F	Birth Date Month	Day	Year	Relationship to You	*If child is over 21 years of age and attending school full-time, provide name of school. If child is handicapped, state nature of disability to apply for coverage beyond plan's age limits.*
01	Spouse								
02	1st Child								
03	2nd Child								
04	3rd Child								
05	4th Child								

Do you have duplicate coverage under another Extended Health or Dental plan (e.g. your spouse's group plan)? If yes, provide details below:

Name of Insurance Company _____ Group Number _____ ID Number _____ ☐ EHC ☐ Dental

Partial Waiver

The Information below must be completed for partial waiver due to coverage under another plan
I elect to waive the benefits checked below because comparable coverage is provided to me and/or my dependents under another group plan:

▶ **For myself and my dependents.....** ☐ Extended Health Care ☐ Dental Care **OR** ▶ **For my dependents only.....** ☐ Extended Health Care ☐ Dental Care

Is this your Spouse's group plan ☐ Yes ☐ No **(If No, provide Details)** _____

Beneficiary Designation

Beneficiary Designation (use full legal name – e.g. Mary Jane Doe, not Mrs. John Doe)
I designate as revocable beneficiary in the event of my death:

_____ _____ _____%
Full Legal Name Relationship Share of Proceeds

_____ _____ _____%

Trustee Designation (complete if beneficiary is under age 18)
I appoint as revocable Trustee to receive any amount which may be due my beneficiary, while such beneficiary is a minor:

_____
Full Legal Name

I agree to the conditions of the contract(s) between my employer and the insurer(s) and authorize my employer to deduct required contributions from my earnings. On behalf of myself and my dependents I authorize BBD Inc. and all insurers to exchange the information detailed in this application, and any other benefit related information contained in files regarding me or my dependents, either now or in the future, for the purposes of administration and/or management of the group insurance policies issued by the insurers. I understand that this original document and all other original documents pertaining to me and my dependents are the property of BBD Inc. and will be permanently retained by BBD Inc. as required by the insurers. I confirm that the information I have provided is true and complete.

X _____
Signature of Employee **Date**

▶ Employer – Complete this section ◀

Employee's Earnings | **Hours Per Week**

$ _____ ☐ Annually ☐ Monthly ☐ Weekly ☐ Hourly

Payroll Number (optional)

Department Number | **Employee Number**

Employee's Occupation | **Class Code**

Date of Employment (New Employee)			Date of Rehire (Reinstatement)			Effective Date (for administrator use only)		
Month	Day	Year	Month	Day	Year	Month	Day	Year

I confirm that this employee is eligible to apply for coverage and that the information I have provided is true and complete.

X _____
Authorized Signature of Employer **Date**