ID #

MATRIX ENROLLMENT FORM or CHANGE FORM

NOTIFICATION

☐ NEW ☐ REINSTATEMENT ☐ BENEFIT CHANGE

☐ Add Dependent ☐ Delete Dependent ☐ Other Change _____

Effective Date: _____

EMPLOYER DATA (Please type or print clearly in ink)

If enrollment is not made on time, coverage may be limited or denied based on proof of insurability.

Employer _____ Policy # _____ Div. # _____ Class _____

Full-time Hire Data (reinstatements indicate date of re-hire) ____ ____ ____ (mm dd yr)

Hours worked (per week) _____

Description of Occupation _____

Part-time Hire Data ____ ____ ____ (mm dd yr)

Earnings $ _____ ☐ Annually ☐ Bi-Weekly ☐ Hourly ☐ Monthly

Employer's Signature: _____ Position: _____ Date: _____

EMPLOYEE STATEMENT

You and your dependents must be insured through your Provincial Benefit Plan in order to participate in Matrix's group insurance plan.

Employee's Surname _____ First Name _____

Address _____ City _____ Prov. _____ Postal Code _____

Date of Birth ____ ____ ____ (mm dd yr) Sex: ☐ F ☐ M

Marital Status ☐ Single ☐ Married ☐ Common-law ☐ Div./Separated If Common-law indicate date of co-habitation ____ ____ ____

☐ **Single**, Extended Health Care
☐ **Single**, Dental
☐ **Family**, Extended Health Care
☐ **Family**, Dental
☐ **Waive**, Extended Health Care
☐ **Waive**, Dental

Please indicate if you have coverage* through your spouse.

E.H.C. ☐ No ☐ Yes
Dental ☐ No ☐ Yes

Spouse's Group Insurance Carrier _____

To waive coverage you and your dependents must have coverage* through your spouse.

* If comparable coverage ceases please advise with 31 days or you will be subject to medical examination (at your expense).

BENEFICIARY DESIGNATION

If a designated beneficiary is a minor, consider naming a Trustee

Full Legal Name _____ Relationship to Employee _____

ELIGIBLE DEPENDENTS

	Surname	First name	M/F	Date of Birth mm/dd/yy	*Student check box	Surname	First name	M/F	Date of Birth mm/dd/yy	*Student check box
Spouse					☐					☐
Child					☐					☐
					☐					☐
					☐					☐

* Students over 21 and under 25 are only eligible if they submit proof of full-time registration
Children of common-law spouses must reside with the employee in order to be eligible.

AUTHORIZATION

I am applying for Group Insurance for which I am or may become eligible under this plan, according to the information I have provided on this form.

I hereby authorize my employer, group plan administrator, insurer or their agents, or any other person or organization having any relevant information regarding me, my spouse or dependents to release and exchange any and all information necessary for the purposes of determination of eligibility for benefits and administration of the group benefits plan. I confirm I am authorized to act on behalf of my spouse and/or dependents for such purposes.

I declare that the information provided is true, complete and accurate. Any copy of this authorization shall be as valid as the original.

Employee Signature X_____ Date _____

700 Finley Avenue, Unit 5, Ajax, Ontario L1S 3Z2 Tel: (905) 426-8850 Outside Toronto: 1-800-265-4455 Fax: (905) 426-9844

EFFECTIVE DATE	CHANGES

OFFICE USE ONLY

Effective Date	Life Volume ☐ GF	WI Volume ☐ GF	LTD Volume ☐ GF	Extended Health Care ☐ Single ☐ Family ☐ Nil	Dental ☐ Single ☐ Family ☐ Nil