



**CSI-CANADA INSURANCE PLAN AND TRUST**  
**EMPLOYEE ENROLMENT AND CHANGE FORM**  
 Contract No. 84168 issued by Manulife Financial

<input type="checkbox"/> New Enrolment or <input type="checkbox"/> Change: (check boxes) →	<input type="checkbox"/> Change Coverage <input type="checkbox"/> Add Dependant <input type="checkbox"/> Delete Dependant <input type="checkbox"/> Change Student Status <input type="checkbox"/> Change Name <input type="checkbox"/> Change Co-ordination of Benefits <input type="checkbox"/> Change Beneficiary <input type="checkbox"/> Change Address for CSI (remember to report new address to Manulife Financial on claim forms)
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School Name \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_

SIN # \_\_\_\_\_ Email Address \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Full Address \_\_\_\_\_

Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_      Employment Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_      Gender: Male   
Day Month Year      (or Eligibility Date) Day Month Year      Female

**COVERAGE SELECTIONS** *Complete both columns.*

<b>Flex Plans</b> (choose one) <input type="checkbox"/> Flex Option 1 <input type="checkbox"/> Flex Option 2 <input type="checkbox"/> Flex Option 3 <input type="checkbox"/> Flex Option 4 <input type="checkbox"/> Flex Option 5 <input type="checkbox"/> <b>Healthcare Spending Account</b> \$ _____	<input type="checkbox"/> <b>Basic Benefit Plan</b> (select single or family) or <input type="checkbox"/> Single or <input type="checkbox"/> Family (complete dependant coverage below) The Basic Benefit Plan includes Health, Dental, Life, AD&D, STD and LTD.  <input type="checkbox"/> <b>Limited Benefit Plan</b> (select single or family) <input type="checkbox"/> Single or <input type="checkbox"/> Family The Limited Benefit Plan includes Life, AD&D, STD and LTD and is available only to those who have Extended Health and Dental Coverage through their spouse's employer's plan.
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**DEPENDANT COVERAGE** *(for Basic Family coverage only)* Spouse and Dependent Children Information

<input type="checkbox"/> Add Dependant(s)	<input type="checkbox"/> Delete Dependant(s)	Effective Date _____	Reason _____		
<u>First Name</u>	<u>Last Name (if different)</u>	<u>Date of Birth</u> dd/mm/yyyy	<u>Gender</u> M F	<u>Full-time</u> <u>Univ. Student</u>	<u>Disabled</u> <u>Child</u>
Spouse _____	_____	____/____/____	<input type="checkbox"/> <input type="checkbox"/>		
Child _____	_____	____/____/____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child _____	_____	____/____/____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child _____	_____	____/____/____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child _____	_____	____/____/____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**CO-ORDINATION OF BENEFITS INFORMATION:** *Important information for paying claims.*

My spouse has coverage under his/her employer's plan: Health (choose one)  Single  Family  None  
 Dental (choose one)  Single  Family  None  
 If this is a change in co-ordination of benefits, please list the effective date of the change \_\_\_\_\_

My child(ren) attending college or university full-time have coverage under a student plan: Child's Name \_\_\_\_\_  Health  Dental  
 If this is a change in co-ordination of benefits, please list the effective date of the change \_\_\_\_\_

If your dependent children have coverage under a former spouse's plan, please attach a separate note with details about their coverage.

**BENEFICIARY** *Must be completed by all new enrollees.*

Beneficiary designation is for Death Benefits ONLY. You or your spouse may change the beneficiary at any time without the beneficiary's consent.  
 If your beneficiary is a minor, please contact CSI.

**Applicant's Beneficiary:** Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Relationship \_\_\_\_\_

If you have selected family coverage under the Basic or Limited Benefit Plan, please name your spouse's life insurance beneficiary.  
**Spouse's Beneficiary:** Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Relationship \_\_\_\_\_

**AUTHORIZATION** *Must be completed to process.*

I am authorized to disclose information about my spouse and dependants in order to enrol them in the Plan. By enrolling in this Plan, I authorize Manulife Financial, its agents and service providers to collect, use, disclose and exchange information collected in this form to underwrite, administer and pay claims. I also authorize the Plan Sponsor, Christian Schools International (CSI) and its agents and service providers and my employer to collect, use, disclose, and exchange the information collected in this form to manage, administer, and arrange for benefits for me and my spouse and/or dependants, as applicable and to make any necessary payroll deductions which may be required. I authorize the use of my Social Insurance Number for administrative purposes. If my participation in this Plan and/or employment with a member school should end for any reason, this authorization will continue for the purposes of managing, administering, and arranging for benefits that may continue after my participation and/or employment terminates. I declare that the information above is accurate and true. Inaccurate information may invalidate my claim and/or participation in the Plan.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Employer Section for New Enrollees**

Occupation \_\_\_\_\_ Hrs. Worked/Wk. \_\_\_\_\_ Earnings \$ \_\_\_\_\_  Mo.  Annual      ci/enrolmentchangeform0911