CHRISTIAN SCHOOLS INTERNATIONAL

# CSI-CANADA INSURANCE PLAN AND TRUST

## EMPLOYEE ENROLMENT AND CHANGE FORM

Contract No. 84168 issued by Manulife Financial

| ☐ New Enrolment<br>or<br>☐ Change: (check boxes) → | ☐ Change Coverage ☐ Add Dependant ☐ Delete Dependant ☐ Change Student Status<br>☐ Change Name ☐ Change Co-ordination of Benefits ☐ Change Beneficiary<br>☐ Change Address for CSI (remember to report new address to Manulife Financial on claim forms) |
|---|---|

School Name _____ City _____ Province _____

SIN # _____

Last Name _____ First Name _____

Full Address _____
(street) (city) (province) (postal code)

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

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

☐ **Standard Plan**

or

**Flex Plans** (choose one)

- ☐ Flex Option 1
- ☐ Flex Option 2
- ☐ Flex Option 3

☐ **Healthcare Spending Account**

$_____

☐ **Basic Benefit Plan** (select single or family)

or ☐ Single or ☐ Family (complete dependant coverage below)

The Basic Benefit Plan includes Health, Dental, Life, AD&D, STD and LTD.

☐ **Limited Benefit Plan** (select single or family)

☐ Single or ☐ 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.

**DEPENDANT COVERAGE** *(for Basic Family coverage only)* Spouse and Dependent Children Information

☐ Add Dependant(s) ☐ Delete Dependant(s) Effective Date _____ Reason _____

| | First Name | Last Name (if different) | Date of Birth dd/mm/yyyy | Gender M | Gender F | Full-time Univ. Student | Disabled Child |
|---|---|---|---|---|---|---|---|
| Spouse | | | / / | ☐ | ☐ | | |
| Child | | | / / | ☐ | ☐ | ☐ | ☐ |
| Child | | | / / | ☐ | ☐ | ☐ | ☐ |
| Child | | | / / | ☐ | ☐ | ☐ | ☐ |
| Child | | | / / | ☐ | ☐ | ☐ | ☐ |

**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 enroling 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