CHRISTIAN EDUCATION HEALTH PLAN
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RETIREE INSURANCE ENROLLMENT AND CHANGE FORM

☐ New Retiree Enrolment
☐ Change: (check boxes) →
☐ Change Coverage ☐ Change Address ☐ Add Dependent ☐ Delete Dependent
☐ Change Name ☐ Change Co-ordination of Benefits ☐ Change Beneficiary

SIN # _____ or Member ID# _____

Last Name _____ First Name _____

Address _____ City _____ Province _____ Postal Code _____

Date of Birth ____/____/____ (Month / Day / Year) Retirement Date ____/____/____ (Month / Day / Year) Gender: Male ☐ Female ☐

E-mail Address _____

Former School Name _____ City _____ Province _____

RETIREE INSURANCE PLAN Includes Health and Dental (single or family) and Life insurance (Retired Employee)

☐ **Single Coverage**
☐ **Family Coverage**
☐ I choose not to participate in the Retiree Insurance Plan.

☐ **RETIREE OPTION 1**
☐ **RETIREE OPTION 2**

Number of consecutive years of coverage in the insurance plan just prior to retirement _____

DEPENDENT INFORMATION Spouse and Dependent Children

☐ Add Dependent(s) ☐ Delete Dependent(s) Effective Date _____ (Month / Day / Year)

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

CO-ORDINATION OF BENEFITS INFORMATION: *Important 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, list the effective date of 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, list the effective date of change _____

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

LIFE INSURANCE BENEFICIARY - for Death Benefits only. You may change the beneficiary at any time without the beneficiary's consent.

Beneficiary Last Name _____ First Name _____

Relationship _____ Date of Birth _____ (mm dd yyyy) SIN _____

AUTHORIZATION *Must be completed to process.*

I am authorized to disclose information about my spouse and dependents in order to enroll 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 Christian Education Health Plan, 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 dependents, 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 my 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 _____

Please print, sign, and submit by email, mail, or fax.