Strategys
Administrateur en avantages sociaux

Application for enrollment or modification
Group insurance and Benefits Program

Please complete all sections of the form and print in INK.
Section A must be completed by the Plan Administrator and sections B through G by the plan member.

SECTION A – RESERVED FOR EMPLOYER OR ADMINISTRATOR

This section must be completed by the contract-holder.

Employer	Employment date (Y M D)
Contract Number	Eligible as of (Y M D)
Account/Division Number	Province of employment of plan member
Class Number	Normal working hours ___________ hours / week
Participant certificate number (if available)	Annual Salary $_____________________
Occupation / title	Status ☐ Permanent ☐ Temporary

I confirm that the information in Section A is complete and accurate.
Signature of plan administrator ______________________________ Date (Y M D)

SECTION B – PLAN PARTICIPANT INFORMATION

This section must be completed by the __plan member__.

Given name	Date of birth (Y M D)	Address
Family name	Sex ☐ M ☐ F	N. _________________ Apt. _________
Home telephone	Mobile telephone	Street_______________________________
Language ☐ French ☐ English	Email address	City __________________ Prov. ______
		Postal code ______________________

Do you have a husband/wife, common-law partner or civil union spouse? ☐ Yes ☐ No

If you answered **__YES__** to any of these questions, you must complete section C.

Do you have eligible **children** (children under the age of 21, full-time students aged 21 to 25, disabled adults)? ☐ Yes ☐ No

Dependents' life insurance is __mandatory__ if you have a spouse or eligible dependent children.

SECTION C – DEPENDENTS

This section must be completed by the __plan member__.

Given name	Family name	Sex	Date of birth	Status
Spouse :				
		☐ M ☐ F	Y M D	☐ Married ☐ Civil union ☐ Common-law Start date of cohabitation: Y M D
Children :				If aged 21 or older, specify:
		☐ M ☐ F	Y M D	Full time student ☐Yes ☐ No Disabled ☐ Yes ☐ No
		☐ M ☐ F	Y M D	Full time student ☐ Yes ☐ No Disabled ☐ Yes ☐ No
		☐ M ☐ F	Y M D	Full time student ☐ Yes ☐ No Disabled ☐ Yes ☐ No
		☐ M ☐ F	Y M D	Full time student ☐ Yes ☐ No Disabled ☐ Yes ☐ No

You MUST register your eligible dependents at a minimum for Dependent Life Insurance.

SECTION D – BENEFICIARY DESIGNATION

IMPORTANT: DO NOT CROSS/SCRATCH OUT THE INFORMATION ENTERED IN THIS SECTION

This section must be completed by the plan member.

Given name	Family name	Share as a %	Date of birth	Designation *	Relationship to member
Primary Beneficiary:					
		%	Y M D	☐ Revocable ☐ Irrevocable	
		%	Y M D	☐ Revocable ☐ Irrevocable	
		%	Y M D	☐ Revocable ☐ Irrevocable	
		%	Y M D	☐ Revocable ☐ Irrevocable	
		%	Y M D	☐ Revocable ☐ Irrevocable	

The beneficiary's consent is required to change an irrevocable designation. The participant is responsible for the validity of the information and designations of beneficiaries.
* Note: In Quebec, unless you indicate otherwise, if you designate your husband/wife as beneficiary, this designation is irrevocable.

In Quebec, any amount to be paid to a beneficiary when he / she is a minor will be paid on his or her behalf to the parent(s) or legal guardian of that beneficiary.

SECTION E – COMPLEMENTARY HEALTH AND DENTAL CARE PROTECTIONS

This section must be completed by the plan member.

Please tick the box of your choice of supplementary health coverage (including drug coverage):

Status: ☐ Individual ☐ Couple ☐ Single parent ☐ Family ☐ I refuse Protection*

Please tick the box of your choice of dental coverage (if applicable):

Statut: ☐ Individual ☐ Couple ☐ Single parent ☐ Family ☐ I refuse Protection*

* Note : Eligible participants who are resident in Quebec must enroll in the supplementary health and dental coverage. Eligible participants may waive coverage if they are covered by another private plan (spousal plan, professional plan, etc.). Participants waiving benefits must complete section F-Coordination of Benefits.

SECTION F – COORDINATION OF BENEFITS AND / OR WAIVER OF BENEFITS

This section must be completed by the plan member.

Complete only if the participant has a spouse.

Does your spouse have supplementary health insurance under his or her own plan? ☐ Yes ☐ No
If so, what is the status of the coverage: ☐ Individual ☐ Single parent ☐ Family

Is your spouse entitled to dental care under his or her own plan? ☐ Yes ☐ No
If so, what is its protective status: ☐ Individual ☐ Single Parent ☐ Family

Insurer / Administrator of the spouse's insurance plan:	Plan/policy number of spouse's contract:	Spouse's certificate number:

SECTION G – PARTICIPANT'S DECLARATION AND AUTHORIZATION

This section must be completed by the plan member.

I HEREBY WARRANT that the information contained in this form is true and complete and I enroll in the protections outlined above and with the compulsory benefits included in the group insurance plan offered by my employer.

I AGREE that a photocopy, facsimile or electronic version of this declaration and authorization shall have the same validity as the original

I authorize my employer, Strategys - Benefits Administrator, Strategys Mutual, every insurer, reinsurer, medical clinic, health professional, pharmacist, health professional, administrator, organization linked to Strategys or Strategys Mutual, to collect or exchange my personal and dependent information for the purposes of administering the Plan, for the administration of claims, to administer my health file and to take advantage of the benefits under the group insurance contract and benefits contract subscribed to by my employer or my association.

Signature of Participant: ______________________ Date : Y M D