

MEMBER APPLICATION

All dates must be entered as (DD/MM/YYYY).

Member: Please print clearly; completing sections 1-4 and signing section 5. Pass this form onto your Plan Administrator.
Plan Administrator: Please complete sections 6, sign section 7 and submit to Sirius Benefit Plans. Section 8 is for Sirius Benefit Plan use only.

1	Member Info	Last Name		First Name					
		Street Address		City	Prov	Postal Code			
		Email Address		Day Phone Number		Language £ English £ French			
		Gender £ male £ female	Date of Birth (DD/MM/YYYY)	Provincial Health Plan Coverage £ Yes £ No		Native Status £ Yes £ No			
		Marital Status £ single £ married £ common-law - Date of co-habitation:							
2	Other Coverage	Only complete this section if you have a spouse.				EHC		Dental	
		Does your Spouse have coverage through their employer? Name of your spouse's group insurer: _____ Policy no.: _____				£ Yes £ No		£ Yes £ No	
		Are you covered for health and/or dental benefits under your spouse's plan? If yes: I wish to decline benefits for myself & my dependents I wish to decline benefits for my dependents (only I will be covered)				£ Yes £ No		£ Yes £ No	
						£ Yes £ No		£ Yes £ No	
3	Dependent Info	Name		Date of Birth (DD/MM/YYYY)	Sex M or F	Relationship	For over-age dependent children see booklet for definitions of each		
		Last	First					Full-time University or College Student?* Yes or No?	Disabled Dependent* Yes or No?
		Spouse							
		Child							
		Child							
		Child							
*Please complete an overage dependent application if the dependent child is attending college or university (secondary education) or if you wish to submit your dependent child as an overage disabled dependent. Your Plan Administrator can provide you with more information on these two situations.									
4	Beneficiary	Name		Relationship to Member	Percentage cannot exceed 100% in total	For Quebec residents only: Any designation of a "spouse" is considered irrevocable unless you check here £ to stipulate that the designation of the spouse is revocable.			
		Last	First						
Trustee Designation This section is to be completed only if the beneficiary designated above is under the age of majority				I hereby appoint _____ as Trustee to receive any amount due to any beneficiary under the age of 18.					
5	I consent to the collecting, using and disclosing of my personal information for the purposes of communication, underwriting risks, investigating and adjudicating claims, detecting and preventing fraud, compiling statistics and acting as required or authorized by law. I certify that all information in this form is true and accurate. I hereby apply for coverage for which I am, or may become, eligible for. I acknowledge that I only enroll, at this time or any future time, dependents that have authorized me to provide their information and consent to the collection, use and disclosure of their information for the above purposes. I authorize Sirius Benefit Plans, any insurance companies and healthcare providers to exchange information when necessary to determine eligibility and to administer the plan. I designate the above mentioned beneficiary for any benefits payable as a result of my participation in this plan.								
	Member Signature				Date Signed				
6	Plan Administrator	Group #	Firm #	Class	Name of Firm				
		Occupation	Permanent Date of Hire (DD/MM/YYYY)		# of Hours Per Week	Gross Monthly Earnings \$			
7	I confirm that this employee is eligible for coverage and that the information provided is true and accurate.								
	Plan Administrator Signature				Date Signed				

Eff date _____
Class _____
Member _____
Cert _____
Firm _____
Group _____
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