Please send completed forms to:

Kechnie Benefits
262 Queen Street South
Kitchener ON N2G 1W3
T: 519 571-2020 | 866 710-7080
F: 519 571-2424 | 866 710-7888

Group Benefits

Employee Enrolment Application

Section A-Employer Information

Plan Sponsor	Firm Number	Class	Waive 3 Month Waiting Period? ◯ NO ◯ YES
Date Of Full Time Employment (dd/mm/yyyy)	Regular Hours/Week	Employee's Title/Occupation	
Annual Salary			
Plan Administrator/Authorized Signature			Date (dd/mm/yyyy)

Section B- Plan Member Information

◯ Mr. ◯ Mrs. ◯ Miss. ◯ Ms.	Last Name	First Name	Middle Name(s)	Date Of Birth (dd/mm/yyyy)
◯ Single ◯ Married ◯ Widowed ◯ Separated ◯ Divorced ◯ Common-law → Co-habitation Status Effective Date: _____		Sex ◯ Male ◯ Female	Language of Preference ◯ English ◯ French	Home Phone Number ( )
Address (number,street,apt. number)		City	Province	Postal Code
Email Address (optional)				

Section C- Applying for Health & Dental benefits

HEALTH	DENTAL	
		Single Coverage (myself only)
		Family Coverage (myself and my spouse/children)
		None because my spouse has coverage through his/her employer **(Please complete section D)**

Note: You may refuse health & dental benefits for yourself and dependent(s) **ONLY** if you are covered for similar benefits elsewhere. You may apply at a later date for benefits you have refused. Certain conditions will apply. Please see your Plan Administrator for details.

Section D- Coordination of Benefits

(Complete this section if you have coverage through another plan, or your spouse has group coverage through his/her employer)

HEALTH	DENTAL	
		Single Coverage (spouse only)
		Family Coverage (myself and my spouse/children)

Name of Employer: _____
Contact Information: _____
Name of Carrier: _____
Effective date: _____

Section E- Family Information

Dependent's Full Name	Date of Birth (dd/mm/yyyy)	Sex (M or F)	Disabled Dependent? (Yes or No)	Full-Time Student? (Yes or No) If yes, name accredited institution
Spouse				
Child				
Child				
Child				
Child				

Section F- Beneficiary Designation

I hereby designate the following revocable beneficiary to any Life Insurance benefits payable as a result of my participation in the plan. A trustee must be assigned to beneficiaries less than 18 years of age. If a beneficiary is not assigned, "Estate" will be assumed.

Beneficiary Codes:

1 – Primary Beneficiary (person or persons who will receive the proceeds of insurance under the policy upon the death of the insured person*)*

2 – Contingent Beneficiary (person or persons who will receive the proceeds of insurance under the policy upon the death of the insured person and the primary beneficiary)

3 – Trustee (person or persons who is the trustee of a beneficiary or contingent beneficiary under the age of 18*)*

Name (First, Last)	Contact information (if different than the member)	Relationship to Member	Beneficiary Code	Percentage
Name (First, Last)	Contact information (if different than the member)	Relationship to Member	Beneficiary Code	Percentage
Name (First, Last)	Contact information (if different than the member)	Relationship to Member	Beneficiary Code	Percentage
Name (First, Last)	Contact information (if different than the member)	Relationship to Member	Beneficiary Code	Percentage

For Quebec residents only

If beneficiary is chosen as irrevocable, his/her consent is required to change it. Include a signed and dated consent with this form. You are responsible for ensuring the validity of your designation.

In Quebec, the designation of your spouse as beneficiary is irrevocable unless otherwise specified.

If spouse is beneficiary, designation is: ○ Revocable ○ Irrevocable

Section G- Plan Member Signature

I designate the person(s) named above under Beneficiary Designation as my beneficiary. I certify that the information in this form is true and complete, to the best of my knowledge. If applying for benefits for my dependents, I am authorized to release information concerning my spouse and my dependents, for the purposes of determining their eligibility for benefits. If applicable, I authorize my plan sponsor to make deductions from my pay for my group benefits.

Plan Member Signature	Date Signed (dd/mm/yyyy)

For Kechnie Office Use Only:

Date Received:_____ Date Processed: _____ Administrator Initials:_____