KECHNIE BENEFITS

Please send completed forms to:

Kechnie Benefits
447 Frederick Street, 4th Floor
Kitchener ON N2H 2P4
T: 519 571-2020 | 866 710-7080
F: 519 571-2424 | 866 710-7888
Email: benefits@kechnie.com

Group Benefits Employee Enrolment

Section A - To be completed by Plan Policy Administrator

Plan Sponsor		Address			Plan Number
Waive Waiting Period ○ Yes ○ No	Date of Employment (dd/mm/yyyy)	Employee's Title/Occupation	Total Annual Salary		Regular Hours/Week
Class: (Please contact Kechnie Benefits if uncertain)			**Does your organization have a Health Care Spending Account (HCSA)?** ○ Yes ○ No If Yes, provide HCSA Coverage Level for Employee:		
Policy Administrator/Authorized Signatory's Name			Signature		Date (dd/mm/yyyy)

Section B - Employee Information

○ Mr. ○ Mrs. ○ Miss. ○ Ms.	Name (Last, First)			
Address (number, street, apt. number)			City	
Province	Postal Code	Email Address (Required)		
Date of Birth (dd/mm/yyyy)		Phone Number	Provincial Health Care Coverage? ○ Yes ○ No	
Marital Status: ○ Single ○ Married ○ Widowed ○ Separated ○ Divorced ○ Common-law -- Date of Co-habitation ____________		Sex ○ Male ○ Female	Language of Preference ○ English ○ French	○ Smoker ○ Non-smoker

Section C - Applying for Health & Dental Benefits

Note: You may refuse/waive health & dental benefits for yourself and dependent(s) **ONLY** if you are covered for similar benefits elsewhere. ***(If you have benefit coverage elsewhere, you must complete Section D)***. You may apply at a later date for the benefits you have refused. Certain conditions will apply. Please contact Kechnie Benefits for details.

	Health	Dental
Single Coverage (myself only)	○ Yes ○ No	○ Yes ○ No
Couple Coverage (myself and my spouse)	○ Yes ○ No	○ Yes ○ No
Family Coverage (myself and my spouse/children)	○ Yes ○ No	○ Yes ○ No
NONE (because my spouse has coverage through his/her employer)	○ Yes ○ No	○ Yes ○ No

Section D - Coordination of Benefits (Other Coverage)

Where applicable, benefit payments will be coordinated between this plan and the other coverage plan you have access to.

Do you have Coverage through another provider? ○ Yes ○ No *(i.e. another employer, or Spouse/Partner)* If Yes, please provide the following required Coverage details.	Please indicate the type of Coverage you have under the other plan: **Health**: ○ Single ○ Couple ○ Family ○ None **Dental**: ○ Single ○ Couple ○ Family ○ None **Vision**: ○ Single ○ Couple ○ Family ○ None
Name of other Insurer	

Section E - Dependent Information

Please contact Kechnie Benefits for 'Dependent' definitions.

Dependent's Full Name	Date of Birth (dd/mm/yyyy)	Sex (M or F)	Relationship	Full-Time University or College Student (Y/N)	Disabled Dependent (Y/N)	Provincial Health Care Coverage? (Y/N)
Spouse						
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 (required for a beneficiary or contingent beneficiary under the age of 18)

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

Section G - Authorization for Direct Deposit of Claims Reimbursement (Preferred Method)

Kechnie Benefits offers a convenient alternative to receiving cheques for reimbursement of your Health/Dental claim expenses. Simply provide your banking information below, attach a void cheque and your claim reimbursements will be deposited automatically into your bank account. **NOTE:** The account you choose **MUST** have chequing privileges or we are unable to process your request.

By providing this information I authorize the attached banking information to be used for Direct Deposit of claims reimbursements:

TRANSIT NUMBER: ________________ **Bank Code:** _______________ **Account Number:** ____________________________

E-mail Address: ____

E-mail address is required to receive notification of payments.*

Please accept this as authorization for Kechnie Benefits to deposit payments directly into my bank account.

Section H - 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.

At Kechnie Benefits we recognize and respect the importance of privacy and have always been committed to protecting your privacy and personal information. We will limit access of personal information for the purposes identified. We will not use, disclose, or retain personal information for purposes other than those for which it has been collected, except with the consent of the individual as required by law.

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

For Kechnie Office Use Only:

Date Received:______________ Date Processed: ______________ Administrator Initials:_______