

Group Benefits and Pension Enrollment Form

EMPLOYMENT INFORMATION (ALL ARE REQUIRED)	
Employer Name and Benefits ER#	

EMPLOYEE'S Information and Employment Record (ALL ARE REQUIRED)					
Full Legal Name:					
Date of Birth:		Marital status:			
Religion:					
Gender:	Male Female	No. of dependent children (under age 22):		No. of dependent children (22-25)*:	
Mobile number:					
Email address:					
Healthcare coverage (Single, Family, Waived – MUST provide coverage information)		Single Family Waive - enter details below			
		Insurance provider:		Policy:	
Dental coverage (Single, Family, Waived – MUST provide coverage information)		Single Family Waive - enter details below			
		Insurance provider:		Policy:	
Pension contribution level		3%	7%	Waive	Click here to download Pension Enrollment Form (required if not waived)
Voluntary RPP:	\$	Voluntary RRSP:	\$	Voluntary TFSA:	\$

*Disabled dependent or dependent is 22-25 years old and attending full-time in-class post-secondary school)

I, _____, authorized:

- My employer to deduct from my pay and remit to Canada Life the plan member contributions required under the plan, if applicable.
- Canada Life to use my social insurance number for tax reporting purposes where it is required in the administration of the plan.
- Canada Life, any healthcare provider, my Benefit Representative at the local level, the Benefits Administration office, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Canada Life to exchange personal information, when necessary to determine my eligibility for coverage, and to administer the plan.

I agree that a photocopy or electronic copy of this Authorizations and Declarations section is as valid as the original. I certify that the information given is accurate, correct, and complete to the best of my knowledge.

Employee's Signature:	Signature Date:

Employer's Signature:	Signature Date: