Benefits Information Sheet

EMPLOYEE ID	

SECTION 1: Employee Information

Employee Name		**Preferred Name:**	
If using this form to initiate a name change indicate New Name		Gender M ☐ F ☐	
Home/Permanent Address:			
Phone Number:		Alternate Number:	
Primary Campus of Employment		Date of Birth	____/____/____ DD MM YY

SECTION 2: Emergency Contact Information

Primary Contact Name:		Relationship to Employee:	
Phone Number:		Alternate Number:	
Alternate Contact Name:		Relationship to Employee:	
Phone Number:		Alternate Number:	

SECTION 3: Dependent Information (New or Change)

Spouse's Name:	______ Last Name ______ First Name ______ Middle Initial		Date of Birth	____/____/____ DD MM YY
Date of Marriage, Cohabitation or Divorce	____/____/____ DD MM YY	Gender M ☐ F ☐	Check as applicable Add ☐ Delete ☐ Change ☐	
Dependent Name:	______ Last Name ______ First Name ______ Middle Initial		Date of Birth	____/____/____ DD MM YY
Full Time Student (21 – 25 years of age)	Y ☐ N ☐	Gender M ☐ F ☐	Check as applicable Add ☐ Delete ☐ Change ☐	
Dependent Name:	______ Last Name ______ First Name ______ Middle Initial		Date of Birth	____/____/____ DD MM YY
Full Time Student (21 – 25 years of age)	Y ☐ N ☐	Gender M ☐ F ☐	Check as applicable Add ☐ Delete ☐ Change ☐	
Dependent Name:	______ Last Name ______ First Name ______ Middle Initial		Date of Birth	____/____/____ DD MM YY
Full Time Student (21 – 25 years of age)	Y ☐ N ☐	Gender M ☐ F ☐	Check as applicable Add ☐ Delete ☐ Change ☐	
Dependent Name:	______ Last Name ______ First Name ______ Middle Initial		Date of Birth	____/____/____ DD MM YY
Full Time Student (21 – 25 years of age)	Y ☐ N ☐	Gender M ☐ F ☐	Check as applicable Add ☐ Delete ☐ Change ☐	

Employee Signature: ______________________________ **Date:** ________________

For Office use only

Benefit coverage (Health): ☐ **Single** ☐ **Couple** ☐ **Family**

Effective Date of Coverage (Health):
EMHR Report ________________ **(dd/mm/yy)**

Effective Date of Coverage (Dental):
EMHR Report ________________ **(dd/mm/yy)**

Dental code

Class: ☐ **A (FT)** ☐ **B (PT)**

Completed:

H.R. ______ **Initials** ______ **Date (dd/mm/yy)**

Payroll ______ **Initials** ______ **Date (dd/mm/yy)**

DEFINITIONS:

Dependent:

Dependents eligible for benefits are your spouse or common-law spouse and each unmarried child, step-child or common-law child who is under 22 years of age (under 21 years of age for Dental) or under 25 years of age (under 26 years of age for Dental) if attending an accredited educational institute, college or university on a full-time basis. Anyone who is in full-time service in any naval, military or air force will not be eligible as dependents.

The attainment of any maximum age specified above will not terminate the coverage on your dependent child if at the time your child is incapable of self-support due to a mental or physical handicap and relies upon you for support and maintenance.

A dependent who resides outside of Canada and the United States of America is not eligible for benefits. (If you require clarification for student coverage while studying out of country, please contact your local HR office for assistance).

Common-law Spouse:

A person whom you publicly represent as your spouse and have been living with for 12 months.

Common-law Child:

A child of your common-law spouse from another relationship who resides with and is in the care and custody of you and your common-law spouse.

CHANGES TO DEPENDENT INFORMATION:

Please remember that it is **your responsibility** to advise Human Resources of changes to your dependent information, as they occur. Delays in providing this information to HR will result in missed coverage. **Coverage for changes that were missed, or delayed, cannot be backdated.**

Dependent Additions:

According to our policy, the information change must be received at Human Resources within 30 calendar days after you acquire a new dependent, in order for the coverage to commence on the date the dependent is acquired. If the information change is received at Human Resources more than 30 days after you acquire the dependent, you may be required to provide additional health information under the Extended Health Benefits Plan before coverage is approved and coverage will commence on the first day of the month following Human Resource’s notification of such a change.

Dependent Terminations:

If you family situation changes, such that the dependents you have listed are no longer eligible dependents, it is your responsibility to advise your local HR office to implement such changes.

IMPORTANT NOTE: You cannot “opt out” of the Extended Health and Dental Benefits Plan because you have coverage through your spouse’s plan, or another plan, as enrollment is a condition of your employment.