gpm group benefits

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ENROLMENT FORM

Group Number **GPM User ID**

Employee Family Name(s) Employee Given Name(s) Date of Birth (d/m/yyyy)

E-mail

TO BE COMPLETED BY THE ADMINISTRATOR (All participants must be covered under a provincial Health Care Insurance Plan)

Employer Name

Full-Time Hire Date (d/m/yyyy)

Category / Class / Module

Waiting Period
Waived as a condition of employment
Note: The waiver request for the waiting period can be made **only** on or at the initial hire date.

Occupation Annual Salary

Number of Hours Worked Per Week Status: Permanent Temporary Contractual Seasonal

Comments

TO BE COMPLETED BY THE EMPLOYEE

Address (Apt., Civic No., Street, City, Province, Postal Code) Telephone Gender M F Language French English

Are you a foreign worker with a work permit? Yes No

Civil Status

Single Married Common-Law Partner or Spouse (Eligibility for common law spouses begins after 12 months of continuous cohabitation)

If you have a spouse, is he or she covered under another group plan? No If yes: Health: Ind Fam Dental: Ind Fam

Do you have dependent children under the age 26 living in Canada? *Yes No

Are your dependent children covered under another group plan? Health Yes No Dental:: Yes No

* Proof of status will be required if the child is considered disabled or is a full-time student, as defined in your contract.

I Would Like To Have The Following Coverage

Extended Health Care	Individual	Couple	Single-Parent	Family	Exemption*
Dental Care (if applicable)	Individual	Couple	Single-Parent	Family	Exemption*

* Participation is mandatory for you **and** your eligible dependents in accordance with the **Eligibility clause in your Benefits Booklet**. Regardless of your province of residence, you may be exempted from participation in the Extended Health Care and Dental Care coverage if you or your dependents are covered by similar benefits under another group insurance plan.

My Dependents

Family Name(s)	Given Name(s)	Relation	Date of Birth (d/m/y)	Gender M / F
		Spouse		
		Child		
		Child		
		Child		
		Child		

Beneficiary Designation

Note: No crossings-out, liquid paper corrector or any other correction in this section.

Primary Beneficiaries

This section must be completed to designate a beneficiary with respect to the participant's life insurance.

Family Name(s)	Given Name(s)	Share in %	Relation(s) To Participant

Secondary Beneficiaries

A secondary beneficiary will only receive a death benefit if no primary beneficiaries are eligible to receive the benefit.

Family Name(s)	Given Name(s)	Share in %	Relation(s) To Participant

Where Quebec Law Applies:

The designation of a spouse (by marriage or civil union) as a beneficiary is **irrevocable**, unless you check-off the box below:

I request that my designation be revocable

Any amount to be paid to a minor will be paid on his behalf to the parent(s), guardian(s), or curator(s) until he or she reaches the age of majority in his province of residence.

Designation of a Trustee for Minor Beneficiaries (Non applicable in Quebec)

Any amount payable during the minority age of the minor(s) beneficiary (ies) will be paid to the trustee
or, in the absence of a trustee, to the duly appointed guardian of the minor(s) in question, as trustee. Payment of amounts owing to said trustee shall release the insurer of any obligation.

DECLARATION & AUTHORIZATION

I understand that my enrolment and my coverage, and that of my dependents, under the group insurance plan are conditional upon my dependents and I maintaining full coverage under the Public Health Care Insurance Plan in our province of residence. By submitting your Enrolment Form you confirm that the information provided is accurate, precise and true, any false information may result in the rejection of your claims. You authorize GPM and its representatives to: (i) Investigate all providers of goods or services and obtain all information relating to the goods sold and services provided; (ii) Collect information regarding the reimbursement request or the claim; (iii) Obtain, use and disclose personal information concerning you or the persons referred to in your claim, necessary for its due diligence to determine its veracity. Note that we will share information relating to a false declaration or fraudulent claim to the competent authorities as well as to the Policyholder. You also agree that the person to whom the request for information is addressed to, answers the questions submitted for the verification of your claim and our inquiry. I authorize my employer to deduct from my salary any contributions, if necessary, relating to my coverage through the group plan.

Date (d/m/yyyy) Employee's Signature Employer's Signature