

☐ New Application ☐ Update

Please Note: This Registration Form is a legal document and replaces all previous Registration Forms.
Complete all sections and sign. In order to enroll in the Plan, you must complete this Registration Form and send it to Ellement (the address is at the bottom of the second page). Report any changes to your personal information by completing this form and selecting 'Update'.

1. MEMBER INFORMATION

YOU AND YOUR DEPENDENTS MUST BE INSURED UNDER YOUR PROVINCIAL HEALTH PLAN IN ORDER TO PARTICIPATE IN THIS GROUP INSURANCE PLAN.

DO YOU HAVE PROVINCIAL HEALTH COVERAGE? ☐ YES ☐ NO

DO YOUR DEPENDENTS HAVE PROVINCIAL HEALTH COVERAGE ☐ YES ☐ NO

GROUP NUMBER		LOCAL UNION NUMBER:		CERTIFICATE/SOCIAL INSURANCE NUMBER	
LAST NAME				FIRST NAME	
GENDER ☐ Male ☐ Female	LANGUAGE ☐ English ☐ French	MARITAL STATUS ☐ Single ☐ Married ☐ Common-law ☐ Divorced ☐ Widow ☐ Separated			DATE OF BIRTH (MM/DD/YY)
ADDRESS					PHONE NUMBER
CITY		PROVINCE	POSTAL CODE		EMAIL ADDRESS

2. SPOUSE'S INFORMATION

REQUIRED - Date of Marriage: _____

☐ spouse or

Address Same As Member's Address

Indicate if:

☐ common-law spouse

If common-law, you must complete the Declaration below.

LAST NAME		FIRST NAME		DATE OF BIRTH (MM/DD/YY)	
ADDRESS				GENDER ☐ Male ☐ Female	
CITY		PROVINCE	POSTAL CODE		PHONE

DECLARATION OF COMMON-LAW SPOUSE

I _____, do solemnly declare that I consider _____ to be my common-law spouse and our relationship as such commenced on the _____ day of _____, 20_____, and has continued to the present time. I make this declaration conscientiously believing it to be true, and knowing that it is of the same force and effect as if made under oath.

Member's Signature

3. COORDINATION OF BENEFITS

Is your spouse covered under any other health and/or dental plan? ☐ YES ☐ NO
If yes, name of other Insurer _____

Canadian Life and Health Insurance Association (CLHIA) regulations state: A spouse first claims from his/her own plan. Children first claim under the parent with the earlier birthday. If parents are separated/divorced, children claim first under the parent with sole custody.

Benefit	Effective Date		
	Single	Family	None (Month/Day/Year)
Extended Health			
Vision			
Drug			
Dental			

4. DEPENDENTS

Complete this section only when you are changing information pertaining to dependents that have previously been enrolled OR when you are adding/deleting a dependent.

Change Code * (See Below)	Date of Change ** (See Below)	Last Name	First Name	Gender M/F	Date of Birth	Relationship Code (See Below)	Request for Over-Age Coverage Attached? (see note below) Yes / No	Request for Disabled Dependent Coverage Attached? (see note below) Yes / No
	(MM/DD/YYYY)			M/F	(MM/DD/YYYY)		Y/N	Y/N
	(MM/DD/YYYY)			M/F	(MM/DD/YYYY)		Y/N	Y/N
	(MM/DD/YYYY)			M/F	(MM/DD/YYYY)		Y/N	Y/N
	(MM/DD/YYYY)			M/F	(MM/DD/YYYY)		Y/N	Y/N

* **Change Type Codes:** A = Add, C = Change, D = Delete

Relationship Codes: H = Husband, W = Wife, CL = Common-Law Spouse, S = Son, D = Daughter, SC = Stepchild, GC = Grandchild, CC = Common-Law Child

** For eligible children, state date the child became a dependent if other than date of birth. Please note that dependent children are covered for health and dental benefits until their 18th birthday. You can continue coverage for your over-age dependent children until their 25th birthday if they are a full-time student or indefinitely if they are permanently disabled and incapable of financial self-support. **You must complete the Request for Over-Age Dependent Coverage form.** This form must be resubmitted each school term.

DEPENDENT CHILD COVERAGE

Coverage through anyone other than yourself or your current spouse

Is your dependent child covered under any other health and/or dental plan? ☐ YES ☐ NO	BENEFIT	COVERAGE
If you answered "Yes", please provide details about Insured person's health and dental insurance below.		Yes No
Name of other Insured person providing coverage: _____	Extended Health	☐ ☐
Date of birth of Insured person: _____	Vision	☐ ☐
Effective Date of Coverage: _____	Drugs	☐ ☐
Relationship to dependent: _____	Dental	☐ ☐
Which parent/guardian do dependents live with: _____		

5. BENEFICIARY FOR LIFE INSURANCE

NAME (LAST, FIRST)	RELATIONSHIP	% SHARE	DATE OF BIRTH
			(MM/DD/YY)
			(MM/DD/YY)
			(MM/DD/YY)

- Ellement Consulting Group will retain the original beneficiary nomination and all future beneficiary designations. The legal beneficiary is the named beneficiary on file with Ellement Consulting Group.
- You may wish to consult a legal advisor before designating a beneficiary.
- If no beneficiary is designated, the beneficiary will be your estate.
- If you wish the life insurance proceeds to be divided among two or more beneficiaries, name all of them and indicate their percentage shares, which must total 100%. If one named beneficiary predeceases you, his/her percentage share will be paid to the other beneficiaries pro rata, unless you indicate otherwise.
- If beneficiary is under 18 years of age, please complete Declaration Appointing Trustee.

For Quebec residents only: if you designated your spouse, the designation is irrevocable unless you indicate otherwise. **Revocable**

DECLARATION APPOINTING TRUSTEE

For beneficiaries under 18 years of age

I do hereby appoint _____ as Trustee to receive any amount due to any beneficiary under 18 years of age and declare the receipt of such Trustee shall be a good discharge to the Insurer for the amount so paid;

And I do hereby authorize such Trustee, within his/her discretion, to expend all or any portion of such amount and/or the income there from for the maintenance or education of such minor.

Dated at _____ this _____ day of _____, 20 ____ .
(city, town) (province)

Signature of Witness

Signature of Member

I hereby apply for the benefits for which I am or may become eligible under the group plan ("Benefit Plan") established by my employer. In order to participate in the benefit program established by my employer and to apply for the benefits for which I or my spouse or dependents may be eligible, my social insurance number is required for identification and for income tax purposes. I consent to the use of my social insurance number for those purposes and also consent to the disclosure of my social insurance number to third parties who require it for the purpose of adjudicating claims and maintaining the benefit program. I also consent to the use and disclosure of my personal information or my spouse and dependents personal information, such as the administrator of the plan, the insurer and any professional advisors or consultants when that personal information is needed for the purpose of adjudicating claims or in order to maintain the benefit program. I authorize the release of statistical information (excluding specific medical details) regarding submitted claims (whether submitted on my behalf or on behalf of my spouse or dependents) to my employer or to other third parties such as professional advisors or consultants. I also direct and authorize my employer to deduct from my salary or wages any required contributions which I must make personally in order to become eligible for and remain a member of the benefit program. I certify that the information provided on this form is true and accurate. I understand that if any statement made herein is incomplete or false, any coverage granted may be voided in whole or in part.

A photocopy or electronic version of this form is not valid for recording beneficiary designations.

(MM/DD/YY)

SIGNATURE OF MEMBER

DATE

Please return to:

Ellement Consulting Group
1050-11150 Jasper Ave NW, Edmonton, AB T5K 0C7
E-mail: painters@ellement.ca | Website: www.paintersbenefits.ca
Phone (780) 452-5161 | Toll free: 1-800-770-2998 | Fax (780) 452-5388