MEDIC SOLUTIONS
Group insurance, evolved

GROUP BENEFITS ENROLMENT FORM

3542 Concorde Blvd. East, suite 107, Laval, Quebec H7E 4W1
Tel.: 514-360-1111 | Toll-free: 1-866-518-0633 | Fax: 514-316-3033

Reserved for Medic Solutions	Medic Client No.		Medic certificate No.	

Customer name / Company name	Division	Class

1 PLAN MEMBER DETAILS – *to be completed by plan administrator*

Last name	First name	Date of birth (dd/mm/yyyy)

Address	City

Province of residence	Province of employment	Postal code	Telephone – *(day)*	Telephone – *(other)*

Email address

Gender	Language	Date of employment (dd/mm/yyyy)	Effective date of coverage (dd/mm/yyyy)
☐ Male ☐ Female	☐ French ☐ English		

Total work hours per week	Annual base salary	Commissions	Bonus	Dividends

Occupation	Employment status
	☐ Permanent ☐ Temporary ☐ Contract ☐ Seasonal

Employer's signature — Date of signature (dd/mm/yyyy)

2 ADDITIONAL INFORMATION – *to be completed by the participant*

Marital status	☐ Single	☐ Married	☐ Separated	☐ Divorced	☐ Widowed	☐ Civil Union
Required coverage for medical expenses	☐ Single	☐ Couple	☐ Family	☐ Single-parent	☐ Exempt*	
Required coverage for dental expenses	☐ Single	☐ Couple	☐ Family	☐ Single-parent	☐ Exempt*	

*** Please provide proof of insurance coverage IF exempt.**

Is your spouse covered by his/her employer's plan?		My spouse has Medical Care coverage	☐ Single	☐ Family
☐ YES	☐ NO	My spouse has Dental Care coverage	☐ Single	☐ Family

3 DEPENDENT INFORMATION – *to be completed by the participant*

⚠ You are required to enroll your spouse and/or dependents if your plan includes:
Extended Health Care, Dental and/or Dependent Life coverage.

SPOUSE DETAILS – *complete this section only if you are applying for coverage for your spouse*

	Last name	First name			
1	Gender ○ M ○ F	If common-law spouse, date of beginning of your union: (dd/mm/yyyy)	Date of birth (dd/mm/yyyy)	Age	

DEPENDENT DETAILS

	Last name	First name			
2	Gender ☐ M ☐ F	A child 21 to 25 years of age must be a full-time student and must provide a student eligibility form.	(dd/mm/yyyy)	Date of birth (dd/mm/yyyy)	Age
3	Last name	First name			
	Gender ☐ M ☐ F	A child 21 to 25 years of age must be a full-time student and must provide a student eligibility form.	(dd/mm/yyyy)	Date of birth (dd/mm/yyyy)	Age
4	Last name	First name			
	Gender ☐ M ☐ F	A child 21 to 25 years of age must be a full-time student and must provide a student eligibility form.	(dd/mm/yyyy)	Date of birth (dd/mm/yyyy)	Age
5	Last name	First name			
	Gender ☐ M ☐ F	A child 21 to 25 years of age must be a full-time student and must provide a student eligibility form.	(dd/mm/yyyy)	Date of birth (dd/mm/yyyy)	Age

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4 APPOINTMENT OF BENEFICIARY

Beneficiary irrevocable / revocable: a minor irrevocable beneficiary cannot consent to a charge of beneficiary and a parent or guardian may not sign on behalf of a minor child for this purpose. All beneficiaries are assumed revocable unless you check the irrevocable box below, except in Quebec. In Quebec, if a married or civil union spouse is named beneficiary, the designation is irrevocable unless you check the revocable box below.

Minor beneficiary: Outside of Quebec, you should name a trustee to receive the benefits while the beneficiary is still a minor. In Quebec, the benefits will be paid to the guardian(s) unless you have established a formal trust.

Multiple beneficiaries: Percentages for all beneficiaries must total 100%. If you name more than one beneficiary and do not indicate a share percentage, the benefit will be divided equally among all surviving beneficiaries.

If more space is needed, attach a handwritten letter including your signature.

BENEFICIARIES – *you must initial any changes or deletions. Correction fluid cannot be used.*

Last name	First name	Status	Relationship to you	Percentage
		☐ Revocable ☐ Irrevocable		0%
		☐ Revocable ☐ Irrevocable		0%
		☐ Revocable ☐ Irrevocable		0%
		☐ Revocable ☐ Irrevocable		0%
			TOTAL must be 100%	0%

NOMINATION OF TRUSTEE FOR MINOR BENEFICIARY – OTHER THAN QUEBEC RESIDENTS

Any payments becoming due while the beneficiary(s) is a minor* are to be made to _____,

as trustee, or failing such trustee to the duly appointed guardian of such minor child as trustee. Payments to the trustee will discharge Medic Solutions.

*** A minor is a child who has not reached the age of majority as defined by provincial legislation.**

5 AUTHORIZATION AND SIGNATURE – *you must sign and date the form*

I authorize any medical practitioner, health care professional, medical organization, health care institution, clinic or any other medical or medically related facility, whether private or public, any insurance company or public organization, insurance agent or investigation agent, security agent, employer or ex-employer holding personal information, particularly my, and also my (minor) dependents' medical information, to release and exchange information to establish or review the validity of a claim.

In the event of my death, I specially authorize the beneficiary, heir or official liquidator of my estate to provide information to Medic Solutions or to the insurer and re-insurer of their plan sponsors, upon request, all information and necessary authorizations to review a death claim or to obtain documentary evidence.

The present consent also applies to the collection, use and communication of personal information of my dependents.

I acknowledge that the coverage provided is subject to restriction or reduction clauses, as well as to the exclusions stated in the policy.

I declare that the above answers and statements are full, complete and true, and I agree and understand that these answers are material to the risk and form part of the application and consideration for the insurance applied for.

I acknowledge that this coverage or any portion of this coverage and any future claims may be denied or terminated due to false, incomplete or misleading information.

I hereby apply for benefits for which I am or may become eligible, and authorize payroll deductions, as required.

A photocopy or electronic copy of this enrollment form and authorization is considered as valid as the original.

If an email address is provided, I authorize Medic Solutions to contact me by email. I am aware that there may be PERSONAL information in emails sent to me by Medic Solutions (i.e. Claim statements)

☐ I authorize Medic Solutions to send my participant's kit in electronic format only.

Date (dd/mm/yyyy)	**Participant's signature**

Reset Form