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. _____

To be completed by the employer	Company name	Division	Class

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

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

Address	City

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

Gender ☐ M ☐ F Language ☐ F ☐ E Email address

To be completed by the employer	Date of employment (mm/dd/yyyy)	Effective date of coverage (mm/dd/yyyy)

Total work hours per week	Annual base salary	Commissions	Bonus	Dividends

Occupation	Employment status
	☐ Permanent ☐ Temporary ☐ Contract ☐ Seasonal

Employer's signature Date of signature (mm/dd/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 attach proof of insurance to this application and give it to your employer if you or your dependents are covered by other individual or group insurance.**

Are your spouse and/or dependents insured under another policy? ☐ YES ☐ NO If affirmed, please provide proof of coverage to your employer and register: Name of the insurer: The contract number: My spouse has medical care coverage ☐ Individual ☐ Family My spouse has dental care coverage ☐ Individual ☐ 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 DETALS

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

DEPENDENT DETAILS

2	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.	Date of birth (mm/dd/yyyy)	
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.	Date nof birth (mm/dd/yyyy)	
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.	Date of birth (mm/dd/yyyy)	
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.	Date of birth (mm/dd/yyyy)	

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4 APPOINTMENT OF BENEFICIARY - *to be completed by the participant*

Beneficiary irrevocable / revocable : a minor irrevocable beneficiary cannot consent to a change 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 initialize any changes or deletions. Correction fluid cannot be used.*

Last name	First name	Status	Relationship to you	Date of birth mm/dd/yyyy	%
		☐ Revocable ☐ Irrevocable			
		☐ Revocable ☐ Irrevocable			
		☐ Revocable ☐ Irrevocable			
		☐ Revocable ☐ Irrevocable			

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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 health care professional as well as any public or private health or social services establishment, the medical information office, any insurance company or any public agency and financial institutions, as well as any personal information agent or investigation and security agency, employer, ex-employer holding personal information, including medical information about me and my dependents, to give the insurer, its reinsurers and their service providers any information they may require for the evaluation of the risk or in the event of a claim. I authorize the Insurer, its reinsurers, and their service providers to provide and exchange such information with them.

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.

This consent also applies to the collection, use and communication of my personal information and my beneficiaries or dependents' personal information, pursuant to Medic Solutions' Privacy Policy available on Medic Solutions' website (medicsolutions.ca). I acknowledge having read, understood and accepted this Privacy Policy. I further acknowledge that for the purposes of managing, notably, my claims and information, Medic Solutions will grant me access to a client portal provided by one of its supplier, Solutions Segic Inc. ("Segic"). I agree that when I will use that platform, my personal information and my beneficiaries and dependent's personal information will be disclosed to or will end up on servers managed by Segic. In this regard, I understand that Medic Solutions does not control Segic, which is a partner of Medic Solutions and that Segic has its own privacy and personal information protection policies.

Furthermore, I understand that my personal information or my beneficiaries or dependent's personal information that I may provide on the portal provided by Segic may contain what is considered "sensitive" personal information, namely information of a medical, biometric or otherwise intimate nature, entailing a high level of reasonable expectation of privacy and I expressly consent to that disclosure of sensitive personal information.

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.

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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 would like to receive a printed copy of my Solution M Card, even though I have access to an electronic copy through my secure portal. ☐

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

Reset form