Plan member application

people CORPORATION®
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☐ New employee ☐ Reinstatement

Plan member: Please print clearly. Complete sections 1-5 and return the form to your plan administrator.
Plan administrator for groups: Please complete sections 6 and 7 and submit to People Corporation.

1	**Plan member information**				
	Last name	First name			
	Mailing address	City	Province	Postal code	
	Email address	Daytime phone number	Language ☐ English ☐ French		
	Gender ☐ Male ☐ Female	Date of birth DD/MM/YYYY	Provincial health plan coverage ☐ Yes ☐ No	Indian status ☐ Yes ☐ No	SCIS Number
	Marital status ☐ Single ☐ Married ☐ Common-law - Date of co-habitation: ________________				

2	**Other coverage** Complete this section if you have a spouse.		Health	Dental
	Does your spouse have coverage through their employer? Name of your spouse's group insurer: ________________ Plan number: ________________		☐ Yes ☐ No	☐ Yes ☐ No
	Are you covered for health and/or dental benefits under your spouse's plan?		☐ Yes ☐ No	☐ Yes ☐ No
	If yes:	I want to decline benefits for myself and my dependants OR	☐ Yes ☐ No	☐ Yes ☐ No
		I want to decline benefits for my dependants but maintain coverage for myself	☐ Yes ☐ No	☐ Yes ☐ No

3 **Dependant information**	Name		Date of birth DD/MM/YYYY	Gender M or F	Relationship to plan member	For over age dependent children, see booklet for definitions of each		Indian status
	Last	First				Full-time university or college student?*	Disabled dependant*	
Spouse						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Child						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Child						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Child						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

*Please complete an Over Age Dependant Application if the dependent child is attending college or university or if he/she is an over age disabled dependant. Your plan administrator can provide more information.

4 **Beneficiary**	Name		Relationship to plan member	Percentage (Total cannot exceed 100%)	**For Quebec residents only:**
	Last	First			Any designation of a spouse is considered irrevocable unless you check here ☐ to stipulate that the designation of the spouse is revocable.

Trustee designation	This section is to be completed only if the beneficiary designated above is under the age of majority.	I hereby appoint ________________ as trustee to receive any amount due to any beneficiary under the age of 18.

5 I consent to the collecting, using, and disclosing of my personal information for the purposes of communication, underwriting risks, investigating, and adjudicating claims, detecting and preventing fraud, compiling statistics and acting as required or authorized by law. I certify that all information in this form is true and accurate. I hereby apply for coverage for which I am, or may become, eligible for. I acknowledge that I only enrol, at this time or any future time, dependents that have authorized me to provide their information and consent to the collection, use and disclosure of their information for the above purposes. I authorize People Corporation, any insurance companies and healthcare providers to exchange information when necessary to determine eligibility and to administer the plan. I designate the above-mentioned beneficiary for any benefits payable as a result of my participation in this plan.

Plan member signature	**Date signed** DD/MM/YYYY

6	**Plan administrator**	Group no.	Division no.	Class	Division name	
		Occupation		Permanent date of hire	Number of hours worked per week	Gross monthly earnings

7 I confirm that this employee is eligible for coverage and that the information provided is true and accurate.

Plan administrator signature	**Date signed** DD/MM/YYYY

People Corporation use only:

8 Group ______________ Division ______________ Cert ______________ Member ____________________ Class ______________ Eff date ____________