

Employee Enrollment/Change Form

*For the Canada West Equipment Dealers Association



PART A – To be completed by the Employer

EMPLOYER INFORMATION	
Firm Name	Group # (new groups TO BE ASSIGNED)
Firm Mailing Address	
NOTIFICATION	
<input type="checkbox"/> New Employee <input type="checkbox"/> Rehire Effective (yy/mm/dd)	OFFICE USE ONLY:
Existing Employee Changes	
<input type="checkbox"/> Terminated Employee Effective (yy/mm/dd)	
<input type="checkbox"/> Delete Dependents Effective (yy/mm/dd)	
<input type="checkbox"/> Add Dependents Effective (yy/mm/dd)	
<input type="checkbox"/> Name Change Effective (yy/mm/dd)	<input type="checkbox"/> Address Change Effective (yy/mm/dd)
	<input type="checkbox"/> Salary Change Effective (yy/mm/dd) 1 st of month date only

PART B – To be completed by the Employee

EMPLOYEE INFORMATION			
Surname	First Name	ID # (new employees TO BE ASSIGNED)	
Employee Address			
City	Province	Postal Code	
Birth Date (YYYY/MM/DD)	<input type="checkbox"/> Male <input type="checkbox"/> Female	# of Hours Worked Per Week	
YYYY / MM / DD			
Occupation or Title	Permanent Full-Time Hire Date (YYYY/MM/DD)		
	YYYY / MM / DD		

COVERAGE INFORMATION	
Do you hold a valid Provincial Health Card? <input type="checkbox"/> Yes <input type="checkbox"/> No	Coverage Designation: <input type="checkbox"/> Single <input type="checkbox"/> Family
If applying for LTD, WI or volume based Life and AD&D, provide exact Monthly Salary. \$ _____	
Spouse's Insurance	
Does your spouse have other Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Both <input type="checkbox"/> Single <input type="checkbox"/> Family
Name of spouse's Insurance carrier:	
Indicate one of the following: <input type="checkbox"/> Coordination of Benefits <input type="checkbox"/> Waive Health and/or Dental Coverage(s)	

Please complete reverse side

DEPENDENT INFORMATION					
Surname	First Name	Birth Date (YYYY / MM / DD)	Gender	Relationship to Employee	Full-Time Student?
		YYYY / MM / DD	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N
		YYYY / MM / DD	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N
		YYYY / MM / DD	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N
		YYYY / MM / DD	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N
		YYYY / MM / DD	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N

BENEFICIARY DESIGNATION			
If no beneficiary is assigned then "ESTATE" will be assumed. If benefits are assigned to minor children a trustee must be appointed to act on their behalf. If none is appointed funds will be held by a public trustee.			
Surname	First Name	% Allocated	Relationship to Employee
Surname	First Name	% Allocated	Relationship to Employee
Trustee for Dependent Children			
Surname	First Name	Relationship to Employee	

PERSONAL INFORMATION CONSENT	
<p>The information collected on this form is required for the purposes of considering and, if approved, processing this form for insurance. It may also be used to administer the insurance policy, investigate any claims that may be made under this policy, and for the provision of products and services. This information, and information in existing files may be used by and exchanged among Western Life Assurance Company, their agents, affiliates, partners, subsidiaries, reinsurers, rating agencies and authorized administrators for these purposes, regardless of whether a policy is issued or coverage ceases to be in force. Subject to legal and contractual requirements, the employee may refuse to consent to the collection, use, or disclosure of their personal information for specific purposes by contacting privacy@westernlife.com or by calling 1-888-647-5433 and asking to speak to the privacy office.</p>	
<p>I hereby enroll in the group insurance plan(s) of the Policyholder named herein and authorize my employer to deduct from my earnings amounts sufficient for my contributions (if any) towards premium(s) for group insurance for which I am or may become eligible.</p>	
Signature of Employee	Date Signed
<p>Complete and send to:</p> <p>Canada West Equipment Dealers Association 2435 Pegasus Road N.E. Calgary, Alberta T2E 8C3</p> <p>Fax #: 1-888-442-9332 (toll free) Scan and Email to: info@cweda.ca For questions on completing this form call: 1-800-661-2542 (toll free)</p>	