Enrolment Form – Life, Dependent Life, AD&D, Health & Dental

Please complete this form and return it to:
Johnson Inc.
201 Buchanan Drive
Charlottetown, PE C1E 2E4
Phone: 902-628-3537 or 1-800-371-9516
Fax: 902-368-8941
*** * NOTE: Please make a copy of this form and keep it in your files.***

1 Plan Sponsor/Employer Information

Policyholder Name Prince Edward Island Federation of Agriculture	Farm Name	Phone #
Plan Member hire/re-hire date D D / M M / Y Y Y Y	Plan Member effective date D D / M M / Y Y Y Y	
Insurance company name(s) Medavie Blue Cross & SSQ Financial	Policy/group contract numbers 11317-000/1NV90 &1NV75	Occupation
Date of PEIFA Membership D D / M M /YYYY		Hours worked/week

BASIC COVERAGE APPLIED FOR:
√ Life √ AD&D √ Dependent Life*
* Dependent Life is automatically included if you indicate family status and eligible dependents

2 Plan Member/Employee Information

Last name	First name		Middle initial
Marital status ○ Single ○ Married ○ Common-Law*			* Date of cohabitation for Common-Law D D / M M / Y Y Y Y
Mailing address			Gender ○ M ○ F
City	Province	Postal Code	Birth date D D / M M / Y Y Y Y

3 Plan Member/Employee Coverage and Family Information

Please list all of your eligible dependents, even if you select single coverage or are waiving health and dental due to having spousal coverage.

Do you have a spouse and/or dependent(s) YES NO		(Circle Choice) Required HEALTH Coverage – SINGLE FAMILY WAIVED Required DENTAL Coverage – SINGLE FAMILY WAIVED		
Spouse's last name	Spouse's first name	Spouse's birth date D D / M M / Y Y Y Y		Spouse's gender ○ M ○ F
Child's full name (last, first)	Birth date DD/MM/YYYY	Gender ○ M ○ F	Student ○ Yes ○ No	Disabled ○ Yes ○ No
Child's full name (last, first)	Birth date DD/MM/YYYY	Gender ○ M ○ F	Student ○ Yes ○ No	Disabled ○ Yes ○ No
Child's full name (last, first)	Birth date DD/MM/YYYY	Gender ○ M ○ F	Student ○ Yes ○ No	Disabled ○ Yes ○ No
Child's full name (last, first)	Birth date DD/MM/YYYY	Gender ○ M ○ F	Student ○ Yes ○ No	Disabled ○ Yes ○ No
Child's full name (last, first)	Birth date DD/MM/YYYY	Gender ○ M ○ F	Student ○ Yes ○ No	Disabled ○ Yes ○ No
Child's full name (last, first)	Birth date DD/MM/YYYY	Gender ○ M ○ F	Student ○ Yes ○ No	Disabled ○ Yes ○ No

COORDINATION OF BENEFITS

Do you or any of your dependents have other coverage under any other insurer? ○ Yes ○ No If Yes, complete the following:

Name of the Other Insurer: ______________________

Effective Date of Coverage: ______________________

ID Number/Certificate Number: ______________________

Policy Number: ______________________

Name of Cardholder: ______________________

Cardholder Date of Birth: ______________________

Is the Coordination of Benefits Single or Family Coverage? Please indicate under "Type of Coverage" S for Single or F for Family for the applicable benefits.
Type of Coverage:
All _____ Hospital _____ Extended Health Benefits _____ Vision _____ Drugs _____ Dental _____

To be eligible for benefits coverage, your dependent children may be required to be unmarried, under age 21, or under age 25 if they are a full-time student at a recognized school and dependent on you for financial support. Disabled dependents may be eligible for benefits coverage if they became disabled before the limiting ages above, and are completely dependent on you for financial support. Eligible dependents may vary depending on the benefit plan.

4 Waiver of Benefits

If you waive health and dental coverage and later lose coverage through another plan, you may apply for benefits under this plan within 31 days. Otherwise you and/or your dependents may be required to provide proof of insurability, and your benefits may be limited or denied under this plan.

If you or your dependents are presently covered for health and dental benefits under another benefits plan you may be able to waive coverage for such benefit(s) under this plan.

I waive coverage for myself and my dependents: ○

I waive coverage for my dependents: ○

OPTIONAL LIFE

Are you applying for Optional Life coverage for yourself? ○ Yes ○ No If Yes, complete the following along with a Statement of Health Form:

Amount of Insurance:____________________
Available in units of $10,000 to a maximum of $250,000

Are you applying for Optional Life coverage for a spouse? ○ Yes ○ No If Yes, complete the following along with a Statement of Health Form:

Amount of Insurance:____________________
Available in units of $10,000 to a maximum of $250,000

CRITICAL ILLNESS (CI)

Are you applying for Critical Illness coverage for yourself? ○ Yes ○ No If Yes, complete the following along with a Statement of Health Form:

Amount of Insurance:____________________
Available in units of $10,000 to a maximum of $100,000

Are you applying for Critical Illness coverage for your spouse? ○ Yes ○ No If Yes, complete the following along with a Statement of Health Form:

Amount of Insurance:____________________
Available in units of $10,000 to a maximum of $100,000

Are you applying for Critical Illness coverage for your children? ○ Yes ○ No If Yes, complete the following along with a Statement of Health Form:
Available in a flat coverage of $10,000

5 Plan Member/Employee Beneficiary

If you designate a beneficiary who is:

(a) a minor (depending on province of residence), or
(b) mentally incapacitated

you should also designate a Trustee for that beneficiary. If this situation applies to you or you have concerns about your named beneficiary's legal status, please consult a legal advisor for future details. If a Trustee is not named for a minor beneficiary, the proceeds will be paid to the legal guardian (which could be Public Trustee) or into court.

Original beneficiary information will be kept by your Plan Sponsor/Employer.

If there is more than one beneficiary designated and no percentages are allocated then the percentages will be deemed equal among those listed beneficiaries.

If no beneficiary is designated, the proceeds will be paid to your estate.

Beneficiary's last name	Beneficiary's first name
Relationship to Plan Member	Percent allocated* %
Beneficiary's last name	Beneficiary's first name
Relationship to Plan Member	Percent allocated* %
Beneficiary's last name	Beneficiary's first name
Relationship to Plan Member	Percent allocated* %

* percentage allocated must total 100%. If you are designating more than one beneficiary, the total percentage allocated for all beneficiaries *combined* must total 100%.

I appoint ________________________________ as Trustee to receive any amount designated to a beneficiary who is a minor or mentally incapacitated.

For Quebec Residents Only
If you have designated your spouse as beneficiary, the designation will be irrevocable, unless you indicate that you wish it to be revocable below.

I wish to make my designation ○ Revocable ○ Irrevocable

6 Plan Member/Employee Declaration

I hereby apply for benefits under the PEI Federation of Agriculture Insurance Benefit Plan and authorize any required bank deductions.

In order to determine my eligibility for benefits and administer group benefit coverage(s), I give Johnsons (and any relevant carrier as may be applicable) consent to:

Collect and communicate personal information about me from people or organizations including: any health care practitioner, medical facility or provider of health care / dental services, any provincial health insurance plan, insurance company or reinsurer, my plan sponsor or former plan sponsor, government agency, or financial institution(s).

If applying for coverage for my spouse and / or dependents, I confirm that I have consented to collect, use and communicate their personal information for the purposes and in the manner set out above.

I acknowledge that more detailed information concerning how and why Johnson Inc. collects, uses and discloses my personal information is available at www.johnson.ca

If I have declined coverage, I understand that I may not be able to obtain coverage at a later date if I change my mind. My ability to obtain coverage is subject to the specific requirements and rules of the applicable insurance program. I am solely responsible for the decisions to decline or accept coverage reflected in this enrollment form. I understand that I may not make a claim for any loss or damage arising directly or indirectly from the elections made in this form or from my participation in the Plan against the PEI Federation of Agriculture or their successors, or any service provider, employee or agent of the Plan. In signing this form I, and my spouse if applicable, specifically release those parties from any such liability.

The information given on this form is true, correct and complete to the best of my knowledge.

Plan Member Signature

Date Signed