National Farmers Union
Union Nationale des Fermiers

Group Benefits Program

Enrollment Card

Please print in ink. To avoid delays ensure all areas are completed in full.

Plan Member Statement - To be completed in full by the Plan Member:

NFU Member ID Number: _____

Last Name | First Name | Middle Name | Name Commonly Used

Apt. # / House # | Street | City/Town | Province | Postal Code

Home Phone | Email Address

**Health & Dental Coverage	Plan Choice	Plan Effective Date
☐ Single ☐ Family/Couple	☐ Best Value Plan - 80% ☐ Premium Plan - 100%	The first of the month next following date of application.

****Health and Dental are mandatory and cannot be waived.**

Date of Birth	Provincial Health Care	Marital Status	*If common-law is selected, the following is required:
_____ yyyy / mm / dd	Are you covered by the Provincial Health Care Plan? ☐ Yes ☐ No	☐ Single ☐ Married ☐ Common-law* ☐ Separated ☐ Divorced ☐ Widowed	I have been living with and representing: _____ (common-law spouse's name) as my common-law spouse since: _____ yyyy / mm / dd Children of common-law spouse must reside with you to be eligible.
Gender ☐ Male ☐ Female			

Dependent Information When enrolling for dependent and/or family benefits, coverage will be considered **only** if the information below is complete. Please ensure spouse and each dependent child is listed regardless if they have Health & Dental coverage under another plan.

Spouse

Name _____ (Last Name / First Name) Gender ☐ Male ☐ Female

Date of Birth _____ yyyy / mm / dd

Provincial Health Care in Place? ☐ Yes ☐ No

Spouse's Coverage Complete the following if your spouse has coverage through their employer's benefit program, please indicate who is covered for each benefit type:

Prescriptions ☐ Spouse only ☐ Spouse and you only ☐ Spouse, you and dependent children ☐ Spouse and dependent children ☐ Dependent children only

Health Care ☐ Spouse only ☐ Spouse and you only ☐ Spouse, you and dependent children ☐ Spouse and dependent children ☐ Dependent children only

Dental Care ☐ Spouse only ☐ Spouse and you only ☐ Spouse, you and dependent children ☐ Spouse and dependent children ☐ Dependent children only

Child's Last Name	Child's First Name	Gender M / F	Date of Birth yyyy / mm / dd	Relationship to Plan Member	Provincial Health Care in Place? Y / N	*** Full Time Student (age 22 - 25) Y / N	*** Overage Disabled Dependent Y / N

***See Plan Administrator for the applicable form.

Beneficiary Designation

Primary Beneficiary **If no beneficiary is designated, the benefit will be assigned to the Estate.** For additional beneficiaries contact GroupSource for applicable form.

Last Name	First Name	Date of Birth (if minor) ****	Relationship	%

In Quebec, if you name your spouse as the beneficiary, this beneficiary will be irrevocable unless you check the revocable box. ☐ **Revocable beneficiary**

A revocable nomination can be changed at any time without the beneficiary's consent. You cannot change an irrevocable beneficiary nomination unless certain requirements are met.

Contingent Beneficiary **If the Primary Beneficiary predeceases me, I designate the following as my beneficiary:**

Last Name	First Name	Date of Birth (if minor) ****	Relationship	%

In Quebec, if you name your spouse as the beneficiary, this beneficiary will be irrevocable unless you check the revocable box. ☐ **Revocable beneficiary**

****If a minor beneficiary (under the Age of Majority by Province or Territory) has been designated please complete the following Trustee Designation:**

Trustee I hereby appoint the individual named below, who is over the age of majority, as Trustee to receive and disperse monies payable under this group policy for any minor beneficiary:

Last Name	First Name	Relationship to Plan Member

Plan Member Authorization & Declaration - To be signed and dated by the Plan Member:

GroupSource understands that privacy is important. We recognize the sensitive nature of personal information and have taken the necessary measures to protect its confidentiality and proper use. Personal Information is information that can be used to explicitly identify an individual. When a Plan Member applies for coverage, has a change in family status, job classification or earnings, personal information about that Plan Member, their spouse and/or dependents may be collected. This information is used to verify eligibility, process claims accurately, provide accurate billing statements, satisfy the conditions for additional or optional coverage and perform insurance related functions. We do not collect, use or disclose personal information without consent, except where authorized by law. Only authorized personnel have access to your information. Personal information is not used for any purpose other than that for which it is collected. You can find more specific information regarding the collection and use of personal information in the Plan Member Benefits booklet, online at www.groupsource.ca or by writing directly to the Privacy Officer at GroupSource, #200, 5970 Centre Street SE, Calgary, Alberta T2H 0C1

I certify that all the information provided herein is complete and accurate and that I am working on a permanent non-seasonal basis. I hereby apply for group benefits coverage for which I am, or may become eligible. I understand that I must notify GroupSource should I ever reach a period of 90 days without a contract. I confirm I am authorized to act on behalf of my spouse and/or dependents for the purpose of determining their eligibility for coverage. I acknowledge the use of my Social Insurance Number (SIN) for the purposes of tax reporting and authorize its use for identification and administration. I understand that the provision of my SIN for such purposes is optional and may be refused or withdrawn without affecting my benefit coverage. I agree to the terms and conditions of the group insurance contract(s). I have read the information above regarding privacy and hereby authorize GroupSource, the Insurer(s) or their agents and any industry drug pooling entity, to collect, use, disclose and exchange all relevant information about me, my spouse or dependents required to: investigate and assess claims, detect and prevent fraud, compile statistical information to underwrite group risks on a prudent basis and comply with the law.

A copy of this authorization is as valid as the original. The original of this form is required for a Life or AD&D Claim.

…….. Plan Member Signature

……. Date Signed

For GroupSource use only:

Effective Date of Change	Details

GroupSource Use Only
Effective Date _____ **GS ID#**_____ **Class** _____ **Company #**_____

GroupSource is committed to protecting the confidentiality, accuracy and security of the personal information it collects and uses in the course of conducting business.

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Pre-Authorized Debit (PAD) Plan Agreement

I authorize GroupSource and the financial institution designated to begin withdrawals as per my instructions for the monthly regular recurring payments, and/or one-time payments from time to time for payment of all charges arising under my GroupSource account(s). Regular monthly payments for the full amount of services delivered will be debited to my specified account on the 10th of the month.

This authority is to remain in effect until GroupSource has received written notification from me of its change or termination. This notification must be received at least ten (10) business days before the next debit is scheduled at the address provided below. I may obtain a sample cancellation form or more information on my right to cancel a PAD Agreement at my financial institution or by visiting www.cdnpay.ca.

I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. Should I have any questions or concerns regarding this PAD agreement I may contact GroupSource directly.

Plan Member Name _____

Street _____

City _____ Province _____ Postal Code _____

Phone ( ) _____ Fax ( ) _____ Email _____

Type of Service: Business

Please attach a VOID cheque or confirmation of pre-authorized debit information form from your financial institution.

Financial Institution (FI) _____

FI Transit Number ___ ___ ___ ___ ___ / ___ ___ ___
Branch - 5 digits FI - 3 digits

Account Number _____

Account will be debited on the 10th of each month.

Signature of Plan Member _____

Dated at: _____ on _____ 20 _____

GroupSource
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