

Enrolment or Re-enrolment Application

Please print clearly and complete both sides of form.
If required, retain a photocopy for your files.

1 Plan Sponsor/ Employer statement

Enter the Certificate number and Class of the plan member/employee, if known. Otherwise leave blank for Manulife Financial to complete.

Plan/group number(s)	Account number(s)	Division number(s)	Certificate number
Plan Sponsor/Employer			
Provide permanent full time hire date	Date (dd/mmm/yyyy)		
If a re-hire, provide the date previous employment ended and re-hire date	Date (dd/mmm/yyyy)		
Employee's occupation	Class	Regular hrs./week	Annual earnings \$

2 Plan Member/ Employee information

We require this information to enrol you in the plan.

Plan Member/Employee name (last, first, middle initial)		Date of birth (dd/mmm/yyyy)
Sex	<input type="radio"/> Male <input type="radio"/> Female	Province of residence
Language of preference		<input type="radio"/> English <input type="radio"/> French

3 Applying for coverage

A spouse/common-law spouse is considered an eligible dependent under your group plan.

Note: You may refuse benefits for yourself and your dependent(s) ONLY if you are covered for similar benefits under your spouse's plan. You may apply at a later date for benefits you have refused. Certain conditions will apply. Please see your Plan Administrator for details.

Dependent Life

Yes No **Note:** Refusal of this benefit is NOT ALLOWED on an AlphaPlus plan.

Extended Health Care (check one ONLY)

Myself ONLY
 Myself AND 1 dependent
 Myself AND 2 or more dependents
 None, because my spouse has coverage

Please complete spousal information section 5.

Dental Care (check one ONLY)

Myself ONLY
 Myself AND 1 dependent
 Myself AND 2 or more dependents
 None, because my spouse has coverage

Please complete spousal information section 5.

4 For Quebec residents

For Quebec residents age 65 or over

I am participating in the RAMQ drug plan provided by the Quebec government
 I am NOT participating in the RAMQ drug plan provided by the Quebec government

5 Spousal coverage information

You must complete this section if you are required to enrol your spouse and dependents. **If you do not have a spouse, this section does not need to be completed.**

NOTE: If you leave this section blank, you will not be able to use your drug card for your eligible spouse and/or dependent children.

Spousal Health coverage

Does your spouse have health care coverage with another carrier?

Yes No Effective date of coverage (dd/mmm/yyyy)

Spouse's plan covers:

Your spouse only
 Your spouse & yourself only
 Your spouse & children only
 Your spouse, you & your children

Are you

Legally married
 Common-law spouse

If Common law spouse, provide the date the relationship began.

Date (dd/mmm/yyyy)

Spousal Dental coverage

Does your spouse have dental care coverage with another carrier?

Yes No Effective date of coverage (dd/mmm/yyyy)

Spouse's plan covers:

Your spouse only
 Your spouse & yourself only
 Your spouse & children only
 Your spouse, you & your children

Plan/Group Number

Certificate Number

