For Administrator only	
Sent Invite	☐
Sent Welcome	☐
Sent CSR	☐

Fellowship Healthcare Coverage

Name: ____

Street Address: ____

City: _______________________ Province __________________ Postal Code ____________________

Home Phone Number (____) ______-_________________ Cell (___) _____-______________________

Email address: _______________________________ Gender: O Male O Female

Date of Birth: Month _______ Day _________ Year _______

Eligible Date of Employment: Month ___________ Day ___________ Year _________________

Effective date of Coverage: Month ___________ Day ___________ Year _________________

Gross Annual Salary (including housing allowance) $__________________

Social Insurance Number ___________________________________
(used for ID #)

Marital Status: O Single O Married

Spouse's Name (if applicable): ____

Spouse's Date of Birth ___________________________

Name of Church/Organization/Individual paying for insurance premiums:

____

Church Address:____

Refusal of Benefits: Note: Dental coverage can be waived with the knowledge that it will not be available to the employee for a period of 3 years after waiving. Health and/or dental can only be refused if you and/or your dependants are covered by duplicate group benefits through your spouse's employee
I understand the plan of group benefits offered to me, but I decline to participate in:
Healthcare for __ myself and my dependants ___ my dependants only
Dentalcare for __ myself and my dependants ___ my dependants only

Spousal Insurer's name: ______________________________ Plan Number __________________
If you lose spousal coverage you must apply for coverage within 31 days of loss of such coverage. If you do not apply within 31 days, you and your dependants may be required to provide proof of insurability acceptable to Canada Life to be covered. If you are approved, coverage for dental benefits may be limited.