Health Risk Services Inc.

Providing Your Innovative Benefits Solutions

Traditional Plan
Employee Enrolment Form

Health Risk Office Use Only	
Enrol Date	
Member ID	
Adjustments	
Card Ordered	

1) To be completed by EMPLOYER

Company Name:			Group Number:
○ New Application ○ Re-instatement	Reason For Enrolment in Plan: ○ Full-Time Hire	○ Part-time Employee changed to Full Time	○ Employee has lost Spousal Coverage
Permanent Date Employed: (mm/dd/yyyy)	Plan Eligibility Date: (mm/dd/yyyy)		Waive Benefits Waiting Period: ○ Yes ○ No
Earnings: $ ○ Annually ○ Hourly	Hours Worked Per Week:	Class:	Occupation:
Plan Administrator:	Name:	Signature:	Date Signed: (mm/dd/yyyy)

2) To be completed by EMPLOYEE — EMPLOYEE INFORMATION

Last Name:	First Name:		Gender: ○ Male ○ Female	Date of Birth: (mm/dd/yyyy)
Street Address:	Unit #:	City:	Province:	Postal Code:

Home Phone: Business Email:

Other Phone: Personal Email:

Marital Status: Have you registered for Provincial Healthcare in your place of residence? ○ Yes ○ No
(You cannot apply for Benefits without Provincial Healthcare) Healthcare Number:

COORDINATION OF BENEFITS

Do you or any of your dependents have other coverage under another insurer? ○ Yes ○ No

If Yes, Please complete the following: Name of Insurer: _____ Policy Number: _____

Is the coordination of Benefits: ○ Health Single ○ Health Family ○ Dental Single ○ Dental Family ○ Vision Single ○ Vision Family

DECLINING BENEFITS

To decline coverage, you must provide the following information:

Name of Insured Policyholder: _____
Name of Insurer: _____
Policy Number: _____
Insured Certificate ID Number: _____

DEPENDENTS

Relationship	Last Name	First Name	Date of Birth: (mm/dd/yyyy)	Gender	*Student Age 21-26	**Disabled
Spouse				○ Male ○ Female	N/A	N/A
Child				○ Male ○ Female	○ Yes ○ No	○ Yes ○ No
Child				○ Male ○ Female	○ Yes ○ No	○ Yes ○ No
Child				○ Male ○ Female	○ Yes ○ No	○ Yes ○ No
Child				○ Male ○ Female	○ Yes ○ No	○ Yes ○ No

*Student: A dependent child age 21 through 26, attending an Institute of Higher Learning on a full time basis, must provide proof of paid full-time student status for claims to be processed. Complete and return the Over-Age Dependent Eligibility Declaration Form to Health Risk which must be submitted each year/term.

**Disabled Dependent: A certificate confirming the dependent's disability must be provided to Health Risk Services Inc.

STOP LOSS INSURANCE

Have you or any of your dependents, on an individual basis, incurred more than $1,750 in prescription drug expenses in the last twelve (12) month period? ○ Yes ○ No

If yes, indicate the amount incurred: $	Name of applicable person:	Date of Birth: (mm/dd/yyyy)

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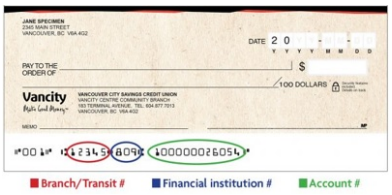
Send to:
Email: claims@healthrisk.ca
Fax: (403) 236-9420
Mail: 50, 12221 - 44th Street SE
Calgary AB T2Z 4H3

DIRECT DEPOSIT FOR CLAIMS

For all Direct Deposit requests regarding claim reimbursements, you must submit one of the following:

- **Physical cheque marked "VOID"**
- **Legible electronic copy of a cheque marked "VOID"**
- **Direct Deposit form (electronic versions from your online banking site are accepted)**

Name of Financial Institution:	*VOID Cheque Example* 
Financial Institution Code: (3 digits)	
Branch Number: (5 digits)	
Account Number: (up to 12 digits)	

To accompany the required proof, please also fill out the section above.

PRIVACY

YOUR PRIVACY – Respecting and Protecting your Personal Information

At Health Risk Services we recognize and respect the importance of privacy. When you apply for coverage, we will establish a ***confidential file*** that contains your personal information. The information that we collect will be used for the purposes of determining your eligibility for coverage for the plan you are applying for and for the administration of this plan. This would include investigating and assessing claims, and creating and maintaining records concerning our relationship. Your file will be kept in the office of Health Risk Services. You may exercise certain rights of access and rectification with respect to the personal information in your file by sending a request in writing to Health Risk Services. We limit access to personal information in your file to Health Risk employees, to persons you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. To review the entire Health Risk Services Privacy Guidelines, visit the Health Risk website: **www.healthrisk.ca – Privacy Guidelines**

AUTHORIZATION AND DECLARATIONS

- I hereby apply for coverage under the group benefits plan sponsored by my employer and administered by Health Risk Services.
- I have read, understand and agree with the contents of the section on this form entitled - 'Your Privacy – Respecting and Protecting your Personal Information'.
- If applying for coverage for my spouse and/or dependents, I confirm that I am authorized to act on their behalf.
- I agree that a photocopy or electronic copy of the Authorization and Declarations section is as valid as the original.
- I give permission to Health Risk Services Inc. to continue educating me regarding my benefits program and/or any additional products and services available to myself and my family through Health Risk Services Inc. I am aware that this information may be forwarded through my employer, to my personal residence or by personal/business emails that have been provided.

BY INITIALLING HERE, I HEREBY AUTHORIZE:

☐ *Required	My plan sponsor to deduct from my pay and remit to Health Risk Services contributions required, **if applicable.**
	Health Risk Services, any healthcare provider, my plan administrator, other insurance or re-insurance under the plan, if applicable; companies, administrators of government benefits or other benefit programs, other organizations, or service providers working with Heath Risk Services to exchange personal information, when necessary to determine my eligibility for coverage and to continue to administer the plan.

SIGNATURE

I certify that all information I have given is true, correct and complete to the best of my knowledge.

Plan Member Signature:	**Date Signed: (mm/dd/yyyy)**