gpm group benefits

250-2 Place Laval, Laval, QC H7N 5N6
T 450.667.7737 | info@gpm.ca | **gpm.ca**

ENROLMENT FORM
Signature on back

Group Number **GPM User ID**

Employee Family Name(s) | Employee Given Name(s) | Date of Birth (d/m/yyyy)

Employee's Email Address

INSTRUCTIONS

1. FILL OUT THE FORM.
2. SIGN THE FORM ON THE SECOND PAGE.

TO BE COMPLETED BY THE ADMINISTRATOR (All participants must be covered under a provincial Health Care Insurance Plan)

Employer Name | Full-Time Hire Date (d/m/yyyy)

Category / Class / Module | Occupation | Annual Salary | Number of hours worked/wk.

Status: Permanent ☐ Temporary ☐ Contractual ☐ Seasonal ☐

Waiting Period ☐ Waived as a condition of employment

Comments

Note: The waiver request for the waiting period can be made **only** on or at the initial hire date.

TO BE COMPLETED BY THE EMPLOYEE

Address (Apt, Civic Number, Street, City, Province, Postal Code) | Telephone

Gender ☐ F ☐ M Language ☐ French ☐ English

Are you a foreign worker with a work permit? ☐ No ☐ Yes

Civil Status ☐ Single ☐ Married ☐ Common-Law Partner or Spouse (Eligibility for common law spouses begins after 12 months of continuous cohabitation)

If you have a spouse, is he or she covered under another group plan? ☐ No If yes: **HEALTH** ☐ Ind. ☐ Fam. **DENTAL** ☐ Ind. ☐ Fam.

Do you have dependent children under the age 26 living in Canada? ☐ No ☐ Yes*

* Proof of status will be required if the child is considered disabled or is a full-time student, as defined in your contract.

Are your dependent children covered under another group plan? **HEALTH** ☐ No ☐ Yes **DENTAL** ☐ No ☐ Yes

I Would Like To Have The Following Coverage

Extended Health Care	Individual ☐	Couple ☐	Single-Parent ☐	Family ☐	Exemption* ☐
Dental Care (if applicable)	Individual ☐	Couple ☐	Single-Parent ☐	Family ☐	Exemption* ☐

* Participation is mandatory for you **and** your eligible dependents in accordance with the **Eligibility clause in your Benefits Booklet**. Regardless of your province of residence, you may be exempted from participation in the Extended Health Care and Dental Care coverage if you or your dependents are covered by similar benefits under another group insurance plan.

Don't forget to sign on the back!

My Dependents

SPOUSE Family Name(s) | SPOUSE Given Name(s) | Gender ☐ F ☐ M | Date of Birth (d/m/yyyy)

CHILD 1 Family Name(s) | CHILD 1 Given Name(s) | Gender ☐ F ☐ M | Date of Birth (d/m/yyyy)

CHILD 2 Family Name(s) | CHILD 2 Given Name(s) | Gender ☐ F ☐ M | Date of Birth (d/m/yyyy)

CHILD 3 Family Name(s) | CHILD 3 Given Name(s) | Gender ☐ F ☐ M | Date of Birth (d/m/yyyy)

CHILD 4 Family Name(s) | CHILD 4 Given Name(s) | Gender ☐ F ☐ M | Date of Birth (d/m/yyyy)

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Group Number **GPM User ID**

Beneficiary Designation

PRIMARY BENEFICIARIES This section must be completed to designate a beneficiary with respect to the participant's life insurance.

Note: No crossings-out, liquid paper corrector or any other correction in this section.

Family Name(s)	Given Name(s)	Share in %	Relation(s) To Participant

SECONDARY BENEFICIARIES A secondary beneficiary will only receive a death benefit if no primary beneficiaries are eligible to receive the benefit.

Note: No crossings-out, liquid paper corrector or any other correction in this section.

Family Name(s)	Given Name(s)	Share in %	Relation(s) To Participant

Where Quebec Law Applies:
The designation of a spouse (by marriage or civil union) as a beneficiary is **irrevocable**, unless you check-off the box below:

☐ **I request that my designation be revocable**

Any amount to be paid to a minor will be paid on his behalf to the parent(s), guardian(s), or curator(s) until he or she reaches the age of majority in his province of residence.

Designation of a Trustee for Minor Beneficiaries (Non applicable in Quebec)

Any amount payable during the minority age of the minor beneficiary (ies) will be paid to the Trustee:

Full Name

or, in the absence of a Trustee, to the duly appointed guardian of the minor(s) in question, as Trustee. Payment of amounts owing to said Trustee shall release the insurer of any obligation.

DECLARATION & AUTHORIZATION

I understand that my enrolment and my coverage, and that of my dependents under the group insurance plan are complementary to those of the Public Insurance Plan and can be conditional upon my dependents and I maintaining full coverage under the Public Health Care Insurance Plan in our province or territory of residence. By submitting my Enrolment Form I confirm that the information provided is accurate, precise and true, and I understand that any false information may result in the rejection of my claims. I authorize GPM, its agents, partners and representatives to: (i) Collect, use, exchange, keep and disclose the information collected on this form or in the context of subsequent communications, and any information relating to my enrolment concerning my dependents or myself, for the purposes of managing, selecting, verifying or processing my insurance product or my claims; (ii) Review my coverage, and determine whether other products of insurance or financial services could meet my needs and provide them to me, and to that end, communicate certain information, excluding health related, to an affiliated partner of GPM; (iii) Investigate all providers of goods or services and obtain all information relating to the goods sold and services provided accepting that the person to whom the request for information is addressed to answers the questions submitted for the verification of my claim inquiry; (iv) Collect information regarding the reimbursement request or the claim; (v) Obtain, use and disclose personal information concerning me or the persons referred to in my claim, necessary for its due diligence to determine its veracity; (vi) Contact me by email in order to send me information concerning my group plan or any subsequent related communication by GPM or one of its affiliated partners to the email address listed in my GPM file. I understand that information relating to a false declaration or fraudulent claim could be transmitted to the competent authorities as well as to the Policyholder. I authorize my employer to deduct from my salary any contributions, if necessary, relating to my coverage through the group plan.

EMPLOYEE'S SIGNATURE **EMPLOYEE'S FULL NAME** (Please print) Date (d/m/yyyy)

EMPLOYER'S SIGNATURE **EMPLOYER'S FULL NAME** (Please print) Date (d/m/yyyy)