

SECTION A: Enrollment/Status Change

Employee Information

Employer Name		OFFICE USE ONLY Certificate ID No. <input type="checkbox"/> Travel <input type="checkbox"/> EHC <input type="checkbox"/> Dental	
Employee Name			
Date of Birth MM/DD/YYYY	Employment Date MM/DD/YYYY	Coverage Effective Date MM/DD/YYYY	
Employee Address			
<input type="checkbox"/> Male <input type="checkbox"/> Female	Email	Division/Class/HSA Maximum	

Coverage & Dependent Information

Coverage Request	HEALTH <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Waive	DENTAL <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Waive	
Spouse Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth MM/DD/YYYY	Relationship
Dependent Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth MM/DD/YYYY	Relationship
Dependent Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth MM/DD/YYYY	Relationship
Dependent Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth MM/DD/YYYY	Relationship
Status Change:	<input type="checkbox"/> Single <input type="checkbox"/> Family	Reason:	<input type="checkbox"/> Marriage <input type="checkbox"/> Common Law Status (must be cohabitating for 12 months) <input type="checkbox"/> Birth <input type="checkbox"/> Divorce/Separation <input type="checkbox"/> Other:

Direct Deposit Please complete the following in order to have your group benefit reimbursements deposited electronically into your bank account

Account Holder Name	Bank Name	
Bank Address	<input type="checkbox"/> Void cheque attached (MANDATORY)	
Bank ID	Branch Transit No.	Account No.

Acknowledgment Agreement: I authorize and direct Youngs-Ten Star Group Benefits Inc. to deposit future group health and dental reimbursements as they come due using electronic funds transfer to the account/financial institution noted above. I am aware it is my responsibility to inform Youngs-Ten Star Group Benefits Inc. of any changes to the above. Sign: _____

SECTION B: Termination

Effective Date MM/DD/YYYY

SECTION C: Address Change

Effective Date MM/DD/YYYY
Old Address:
New Address:

SECTION D: Confirmation

I hereby certify that all the information on this form is true, accurate and complete.

Employee Signature:	Date: MM/DD/YYYY
I confirm/authorize that all information/changes listed above are correct.	
Employer Signature:	Date: MM/DD/YYYY