The Construction Industry's Benefit Plan
Employee Enrolment Form

1 Policy Information

Company Name/Employer	Class	Policy	Division

2 Administrative Information

Last Name	First Name	Date of Employment *(dd –mmm- yyyy)*
Social insurance number (SIN)	Occupation	
Salary	Salary Basis ☐ Annual ☐ Monthly ☐ Bi-weekly ☐ Weekly ☐ Hourly	

3 Employee Information

Date of Birth *(dd –mmm- yyyy)*	BC PharmaCare number	Sex ☐ Male ☐ Female	First Nations Status ☐ Yes ☐ No

Marital status
☐ Single ☐ Married ☐ Common law - Date co-habitation period began *(dd –mmm- yyyy)*:
☐ Separated ☐ Divorced

Address	City	
Postal Code	Province of Residence	Province of Employment

Telephone (Day)	Telephone (Night)	E-mail

Coverage
☐ Single
☐ Family

4 Spouse Information

Last Name	First Name	Date of birth *(dd –mmm- yyyy)*	Sex ☐ Male ☐ Female

Spouse Insurance Information *(Spouse covered under their employer's plan?)*

Covered for Health? ☐ **No** ☐ **Single** ☐ **Family**
Covered for Dental? ☐ **No** ☐ **Single** ☐ **Family**

Insurer Name	Policy Number

5a Dependent Children Information

Last Name	Child first name	Date of birth *(dd –mmm- yyyy)*	Sex	Student	Over-age disabled
			☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No
Last Name	Child first name	Date of birth *(dd –mmm- yyyy)*	Sex ☐ Male ☐ Female	Student ☐ Yes ☐ No	Over-age disabled ☐ Yes ☐ No
Last Name	Child first name	Date of birth *(dd –mmm- yyyy)*	Sex ☐ Male ☐ Female	Student ☐ Yes ☐ No	Over-age disabled ☐ Yes ☐ No
Last Name	Child first name	Date of birth *(dd –mmm- yyyy)*	Sex ☐ Male ☐ Female	Student ☐ Yes ☐ No	Over-age disabled ☐ Yes ☐ No
Last Name	Child first name	Date of birth *(dd –mmm- yyyy)*	Sex ☐ Male ☐ Female	Student ☐ Yes ☐ No	Over-age disabled ☐ Yes ☐ No

5b School Attendance Information *(For dependent children over age 21)*

Child	Name of Educational Institution	Attendance Period *(dd –mmm- yyyy) to (dd –mmm- yyyy)*
Child	Name of Educational Institution	Attendance Period *(dd –mmm- yyyy) to (dd –mmm- yyyy)*

6a Beneficiary Designation

Last Name	First Name	Relationship	Percent %
Last Name	First Name	Relationship	Percent %
Last Name	First Name	Relationship	Percent %
Last Name	First Name	Relationship	Percent %

6b Beneficiary Trustee Nomination *(Please appoint a Trustee if the beneficiary is under the legal age)*

Last Name	First Name	Relationship	Percent %
Last Name	First Name	Relationship	Percent %

7 Personal Information Release

Please list any individuals that you would like to have access to your personal information under the Plan. Personal information includes, but is not limited to, ID number, beneficiary information and claims information.

Last Name	First Name	Relationship
Last Name	First Name	Relationship
Last Name	First Name	Relationship

8 Authorization and Signature

The personal information provided on this form, as well as any other personal information currently held or collected in the future by Benefit Services Ltd. (BSL) is required for and will be used to administer your participation in the plan. In administering your participation in the Plan, personal health related information may be collected from, or disclosed to, insurance companies or other companies that insure the benefits or provide administration and claims handling services; licensed physicians or other healthcare professionals or institutions; and government or regulatory authorities. Personal non-health-related information may also be provided to BSL and the insurance carriers to administer your participation in other BSL programs or to firms conducting surveys for BSL. All personal information will otherwise be kept confidential and secure. You may revoke your consent to the collection, use and disclosure of your personal information, however if consent is withdrawn or refused, that could in some circumstances jeopardize your Plan coverage. Additional information regarding BSL's privacy policy can be obtained by contacting CWU at 1-844-293-2330.

I certify that all of the information I have provided on this form is true, full and complete. I acknowledge that I have read the above information regarding the collection, use and disclosure of my personal information and authorized BSL and the insurance carrier to collect, use and disclose my personal information as described. I authorize my employer to deduct from my pay any contributions I may be required to make toward the cost of the Plan. I authorize the use of my Social Insurance Number for its confidential use by my employer and BSL; in order that hours worked can be accurately reported for the administration of the Plan.

Signature	Date *(dd –mmm- yyyy)*

Contact Us:
1-844-293-2330
benefits@cwcu.ca

Mail Completed Form To:
211- 3823 Henning Drive,
Burnaby, BC V5C 6P3