



The Construction Industry's Benefit Plan Employee Enrolment Form

Section 1 – Employment Info - Employer complete this section

Note: Words in **blue text** are defined on page 3 and 4

Organization/Company		Company No.	Check One: New Application Reinstatement
Employee First Name	Employee Last Name		SIN No.
Occupation	Date of employment (mm/dd/yyyy)	Regular hours worked per week	
Your Name and Title	Email address		Phone No.
Date signed (mm/dd/yyyy)	Signature		

Section 2 – Employee/Family Information - Employee complete this section

Date of birth (mm/dd/yyyy)	Gender Male Female X	PharmaCare Registration No. A -		
Email address			Daytime phone number	
Home address (number, street, suite #)		City	Province	Postal Code

Dependent Information – complete this section if you have a spouse/eligible children More than 4 children, attach list

	First Name	Last Name	Date of Birth (mm/dd/yyyy)	Gender	
Spouse				Male X Female	Married <input type="checkbox"/> Common-Law* *Date of cohabitation (mm/dd/yyyy)
					If over 21:
Child 1				Male X Female	<input type="checkbox"/> Full-time Student <input type="checkbox"/> Disabled
Child 2				Male X Female	<input type="checkbox"/> Full-time Student <input type="checkbox"/> Disabled
Child 3				Male X Female	<input type="checkbox"/> Full-time Student <input type="checkbox"/> Disabled
Child 4				Male X Female	<input type="checkbox"/> Full-time Student <input type="checkbox"/> Disabled

Section 3 – Coordination of Benefit Information

Complete this section if you or your dependents are covered by another EHC or Dental plan

- This information is required to establish which plan is primary and which plan is secondary for your family's claims.
- Do not complete this section if your child(ren) are covered by the BC Healthy Kids program, as it is always the last payer and will not affect claims under your CIBP plan.

Benefits covered by other plan: <input type="checkbox"/> EHC <input type="checkbox"/> Dental		
Who is the cardholder of the other plan?		<input type="checkbox"/> My dependent child(ren)'s non-custodial parent (applicable only if you are the custodial parent) <input type="checkbox"/> My dependent child(ren)'s custodial parent (applicable only if you are not the custodial parent) <input type="checkbox"/> My dependent child(ren)'s parent/step-parent who has joint physical custody with me. Parent/step-parent's birthday (mm/dd):
<input type="checkbox"/> My Spouse Spouse's birthday (mm/dd) <input type="checkbox"/> My dependent child(ren) (e.g. Student plan through university) <input type="checkbox"/> Other (specify):		
Insurance Company	Policy No.	Effective Date (mm/dd/yyyy)
Who is covered by this other plan? (Check all that apply)		
<input type="checkbox"/> Myself <input type="checkbox"/> My Spouse <input type="checkbox"/> All my dependent children, or <input type="checkbox"/> Child 1 <input type="checkbox"/> Child 2 <input type="checkbox"/> Child 3 <input type="checkbox"/> Child 4 <input type="checkbox"/> Child 5		



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Section 4 – Beneficiary Designation - Employee complete this section

Beneficiary Designation for Basic Life and Basic Accidental Death insurance:				
Primary Beneficiary(ies)		To designate more than 3 primary beneficiaries, complete Beneficiary Designation form.		
	Name (first, middle initial, last)	Relationship to You	Type	Percentage
1	First name Middle initial Last name		Revocable Irrevocable	%
2	First name Middle initial Last name		Revocable Irrevocable	%
3	First name Middle initial Last name		Revocable Irrevocable	%
Trustee (Complete if any beneficiary is under the age of majority.)		If you designate a beneficiary as irrevocable, that person's consent is required if you later want to change your beneficiary. The percentages must total 100%. If percentage is left blank, insurance will be split evenly among the beneficiary(ies). If you want to designate more than 3 primary beneficiaries, complete Beneficiary Designation form. If you do not designate a beneficiary, proceeds will be paid to your estate.		
I appoint _____ as Trustee to receive any amount due to any beneficiary under the age of majority.				
Contingent Beneficiary (Optional):		Name (first, middle initial, last)	Relationship to You	

Section 5 – Personal Information Release - Employee complete this section

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.

First Name	Last Name	Relationship to You
First Name	Last Name	Relationship to You
First Name	Last Name	Relationship to You

Section 6 – Declaration and Authorization - Employee complete this section

<p>Protecting your personal information ICBA Benefits is committed to protecting the privacy, confidentiality, accuracy and security of your personal information. Your and your spouse or dependent's personal information may be shared with the insurance company and its reinsurers, your employer, health services providers, and/or administrators of government benefits or other benefits programs for the purposes of verifying eligibility for specific benefits or claims and/or investigating or reporting upon suspected or apparent fraudulent or repeated inaccurate claims behaviour. ICBA Benefits is compliant with Canadian and provincial privacy legislation. Please see our website for our complete Privacy Policy.</p>	
<p>Declaration and authorization I hereby apply for coverage under this policy, and accept its terms and conditions. I authorize the necessary contributions to be made through payroll deductions, if applicable. I authorize my employer and ICBA Benefits, the insurance company and its reinsurers, any healthcare provider, administrators of government benefits or other benefits programs to give, receive and share any personal information regarding my eligibility for coverage and to administer the plan, or those of my dependents, if applicable.</p> <p>I understand that I am responsible for the accuracy of all claims submitted on behalf of myself, my spouse and/or dependents, and that my eligibility and/or entitlement to any or all benefits under the Plan may be suspended and/or revoked without notice in the event that I or my spouse or dependents am found to have made fraudulent or repeated inaccurate claims under the Plan. Further, I hereby authorize my Employer to deduct from my payroll and remit to the Plan any amounts paid to me as a result of fraudulent or inaccurate claims by myself, my spouse or my dependents.</p> <p>I certify that I am covered, and my spouse and children (if applying for coverage) are covered by a provincial medical plan, e.g. Medical Services Plan of BC.</p> <p>I certify that all of the information I have provided on this form is true, correct and complete to the best of my knowledge.</p>	
Signature:	Date Signed (mm/dd/yyyy):

Return completed form to ICBA Benefits via email (indicate the policy number in the Subject line), or by mail.
 If you email the form, do not also send the original by mail.



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Instructions/Additional Information:

Coordination of Benefit Information - This information is required to establish which plan is primary and which plan is secondary for EHC and Dental claims. When a claimant is covered by more than one plan for EHC or Dental, insurance companies follow guidelines set out by the Canadian Life & Health Insurance Association (CLHIA) to determine which plan pays first, known as the primary plan. If the primary plan does not cover the entire expense, the unpaid balance is then submitted to the secondary plan for payment. For more information, see CLHIA's Coordination of Benefit guidelines, which are available to the public on CLHIA's website.

Contingent Beneficiary – If all the primary beneficiaries should die before you, proceeds will be paid to a contingent beneficiary. Should there not be any surviving beneficiaries at the time of your death, the proceeds will be paid to your estate.

Gender – Please indicate the gender on your government issued ID. For gender X, write "X". Note: the insurance company may require a gender of male or female for underwriting purposes.

If over 21 - To be covered on your plan beyond age 21, a child must either meet Canada Revenue Agency's criteria for a full-time student, or be disabled. If your child is disabled, additional information is required to approve coverage beyond the plan's age limits. Contact us for more information.

Primary Beneficiary - If you designate a beneficiary as irrevocable, that person's consent is required if you later want to change your beneficiary. The percentages must total 100%. If percentage is left blank, insurance will be split evenly among the beneficiary(ies). If you want to designate more than 3 primary beneficiaries, complete Beneficiary Designation form. If you do not designate a beneficiary, proceeds will be paid to your estate.

Reinstatement – If the employee previously had coverage under the plan and coverage terminated more than 6 months from the date of rehire, the plan waiting period will be applied to the date of rehire (unless you indicate that you are waiving the waiting period). If the previous coverage terminated less than 6 months from the date of rehire, coverage starts on the date of rehire. Note, both situations are subject to late application rules.

Spouse's Birthday – Why do we need to know your spouse's birthday? If you've listed your spouse in section 2 of this form, you don't have to provide their birthday again here. Otherwise, this is needed to establish which plan is primary and which is secondary. Where the child lives with both parents, the plan of the parent with the birthday that occurs earliest in the year (regardless of age) is the primary plan.

Trustee - Designate a trustee for any beneficiary who is younger than the age of majority in your province.

Type – If you designate a beneficiary as Irrevocable, you cannot change your beneficiary designation without that person's approval. If you designate your beneficiary as Revocable, you may change your beneficiary designation at any time without restriction. Note: If you designate a minor as an irrevocable beneficiary, s/he cannot give consent to a change until they reach the age of majority.

PharmaCare Registration Number – Under the CIBP drug plan, if the insurance company does not have confirmation that you are registered with BC Fair Pharmacare, it will suspend claims payments when your family's claims reach a certain threshold each year. To avoid disruption in your claims under your drug plan, provide your PharmaCare registration number.

Note: This is not a mandatory field.