Please mail original, signed copy to:

bClear benefits
Suite 120 – 4401 Still Creek Drive
Burnaby, BC V5C 6G9

Atrium Enrolment Form

All plan members must complete this form. You can fax the form for immediate processing, but the original must follow. Keep a copy of this form with the Plan Member's personnel file.

REASON FOR COMPLETION: ☐ New Plan Member

Part 1: Employee & Basic Insurance Information

If an employee has dependents and selects single coverage at time of enrolment and then chooses to add these dependents at a later date for any reason the dependents will be considered late applicants and additional paperwork will be required.

Employer Group Name ______

Employee's Last Name ______ **First Name** ______ **Initial** ______ **SIN** ______

Mailing Address ______ ___/___/___ **Birthdate (MM/DD/YY)**

City ______ **Province** ______ **Postal Code** ______

Do you have provincial health coverage? ☐ Yes ☐ No

Sex ☐ Male ☐ Female

Family Status ☐ Single ☐ Family

If your spouse is common law, indicate the date of cohabitation: ___/___/___ (MM/DD/YY)

Definition of spouse: a person of the same or opposite sex who is either married to you or has been living with you for at least 12 months.

Dependent	Dependent's Last Name	First Name	Initial	Birthdate (M/D/Y)	Sex (M/F)	Provide name of school below if child is over 19 and studying full-time. If child is disabled and over 19, indicate nature of disability and attach details.
01 Spouse				/ /		
02 1st Child				/ /		
03 2nd Child				/ /		
04 3rd Child				/ /		

Part 2: Spousal or Other Coverage

Spouse's Plan Information	Benefit	Name of Carrier	Group Number	Certificate Number	Single/Family Coverage
	☐ Health				
	☐ Dental				

Part 3: Change of Beneficiary Designation

Last Name	First Name	Initial	Share of Proceeds (%)	Relationship to Employee	Name of Trustee for Beneficiaries Under the Age of Majority (19 in BC)	If a resident of Quebec* (please indicate)
						☐Revocable ☐Irrevocable
						☐Revocable ☐Irrevocable

To apply for Optional Life and/or Voluntary AD&D, please complete the separate application forms for these benefits. You will need to designate a separate beneficiary for each of these benefits on the applicable form.

*Where Quebec laws apply, a spouse beneficiary is irrevocable unless you make the designation revocable. An irrevocable beneficiary designation cannot be changed without the written consent of the irrevocable beneficiary.

I consent to the collection, use, and exchange of my personal information by my plan sponsor, the administration of my retirement, savings, and other group benefits programs, the agents retained by my plan sponsor of the administrator, the insurance company providing benefits, and/or other person who requires information for the purpose of retirement, savings or other group benefits plan administration. I authorize these parties to obtain, and exchange between them, any information about me, my spouse, or my dependent children that they require for the purposes of determining my benefit entitlements, and for record-keeping, file identification, reporting, underwriting, procurement of health information, claims adjudication and resolution, program management, and other services provided to me and my plan sponsor from time to time. I confirm that I have obtained the consent required of my spouse and any dependent children over the age of majority to permit me to give the above consent as it relates to their personal information. I hereby confirm the above beneficiary designation, which replaces any previous revocable beneficiary. I reserve the right to change my revocable beneficiary designation at any time. I hereby apply for group insurance benefits under my plan sponsor's plan and authorize any required deductions. If I should receive a settlement from, or a judgement against, a liable third party for wage loss, extended health, or other benefits covered under my group plan, I agree and authorize the third party to reimburse the insurance company providing benefits up to the amount of benefits advanced to me pending such settlement or judgement. I consent to the use of my social insurance number for tax reporting purposes and as an identification number where it is required in the administration of the plan.

I understand that on the date my insurance becomes effective I must be actively at work. I also understand that on the date the insurance of my dependent(s) becomes effective that they cannot be confined to hospital. I certify that the information given above is true and complete.

DECLARATION: I work a minimum of 30 hours per week.

Employee Signature ______ Date Signed (MM/DD/YY) ___/___/___

Part 4: For Plan Administrator/Employer Use Only (PLEASE COMPLETE ALL PARTS)

______ Occupation/Position ___/___/___ Date of Hire (MM/DD/YY) **44055** Account/Billing # ______ Div # (if applicable)

$______ per______ Earnings Hrs Worked/Week ___/___/___ Effective Date (MM/DD/YY) ______ Authorized Signature (Plan Administrator)