nova scotia health authority

Group Insurance Enrollment Form for NSGEU, Confidential Excluded, Management

Name of Policyholder	Employee ID	Effective Date of New Coverage (to be entered by administrator)
Nova Scotia Health Authority		

Last Name	First Name	Initial(s)	Social Insurance Number

Birth Date: Day	Month	Year	Sex (M/F)	Telephone# Home / Work
				_____

Address Street & No.

City or Town | Province | Postal Code

Marital Status - check one and please indicate dd/mm/yy

Married ☐	Common-law spouse ☐ (Date of Cohabitation)	Single ☐	Widow(er) ☐	Divorced ☐	Separated ☐

Coverage Required: **Health** Single__ Family__ **Dental** Single__ Family__ **Dependent Life (optional)** __

Coverage Waiver Information

***Due to my health/dental coverage under another plan, I elect not to participate in the NSHA plan: Health__ Dental__**

*Proof of coverage is required, i.e. a letter from the administrator/insurer confirming: *Name of insurer, Policy number Coverage date, Type of coverage.* ***Coverage will not be waived until this letter is received.***

Dependent Information - Complete if applying for Dependent Life or Family Health or Family Dental

	Last name, First Name and Initials	Sex (M/F)	Date of birth (d/m/y)	Dependent Status** (indicate relationship for child of not natural or adopted)
Spouse				
Child				
Child				
Child				
Child				
Child				
Child				

**Child, S-Student (college/university), Disabled

Beneficiary Designation for Basic Life and Basic Accidental Death and Dismemberment Insurance

Last Name and Full First Name	Percentage	Relationship

Name of Trustee(s) if Beneficiary is under age 18: _____

Declaration

I am applying for insurance coverage in accordance with the provisions and conditions of the Group Insurance Contract issued at the policyholder's request. I authorize the policyholder to deduct from my earnings any required contribution for the insurance to which I am or may be entitled. I authorize the use of my Social Insurance Number for group insurance identification purposes and as required by law, for income tax reporting.

Signature of Employee	Date

Witness (Please Print)	Date

Witness Signature	

Workforce Operations Advisor	Date

The original signed form is legally required to update your beneficiary information.