MEMBER ENROLLMENT FORM

Please complete this form to enroll in the CDWA group benefits plan.

Benefits by Design

CDWA Canadian Dog Walkers Association

Please mail the original completed form and copies of 2 government issued identification to CDWA: 343 Bain Ave., Toronto ON M4J 1B9.

TO BE COMPLETED BY THE MEMBER

SECTION A: MEMBER INFORMATION

BUSINESS NAME			
MEMBER LAST NAME		MEMBER FIRST NAME	
MEMBER'S OCCUPATION			
	MEMBER EARNINGS $_____ ☐ ANNUALLY ☐ WEEKLY ☐ MONTHLY ☐ HOURLY		HOURS WORKED PER WEEK

I confirm that this member is eligible to apply for benefits coverage and that the information I have provided is true and complete.

X_____ _____

AUTHORIZED SIGNATURE OF MEMBER — DATE (mm-dd-yyyy)

TO BE COMPLETED BY THE MEMBER

SECTION B: MEMBER INFORMATION

HOME ADDRESS			CITY	PROVINCE / POSTAL CODE
DATE OF BIRTH (mm-dd-yyyy)	SEX ☐ M ☐ F	LANGUAGE ☐ ENGLISH ☐ FRENCH	PERSONAL EMAIL ADDRESS _____ *Disclaimer: Benefits by Design Inc. respects employee privacy. This email address will only be used to discuss conversion options upon termination of this plan.*	

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ COMMON LAW* ☐ WIDOWED

DATE OF COHABITATION (mm-dd-yyyy) _____

**Date of cohabitation is mandatory if Common Law. Common Law dependents are eligible after one year.*

ARE YOU COVERED UNDER YOUR PROVINCIAL HEALTH PLAN?	ARE YOU IN CANADA ON A WORK VISA/PERMIT?
☐ YES ☐ NO*	☐ YES* ☐ NO
**If you don't have coverage through your provincial health plan, you still qualify for benefits with some restrictions. Your Benefits by Design Inc. Customer Service Representative will be in touch to provide further details.*	**Copy required to enroll in this plan. If disability benefits are included in your group plan, you're eligible provided your work visa is 2 or more years, or if less than 2 years, you have applied for permanent residency. You must also have coverage under a provincial government health insurance plan.*

Member Initial: ☐

SECTION C: PARTIAL WAIVER

Complete this section to partially waive benefits due to coverage under another plan. By completing this section, I elect to waive the benefits checked below because comparable coverage is provided to me and/or my dependents under another group plan:

INSURANCE COMPANY	GROUP NUMBER	ID NUMBER

FOR MYSELF AND MY DEPENDENTS: ☐ I waive Extended Health Care ☐ I waive Dental Care

FOR MY DEPENDENTS ONLY: ☐ I waive Extended Health Care ☐ I waive Dental Care

SECTION D: DEPENDENT COVERAGE

RELATION	LAST NAME	FIRST NAME	DATE OF BIRTH (mm-dd-yyyy)	SEX	IF CHILD IS OVER 21, PLEASE SPECIFY NAME OF SCHOOL AND/OR NATURE OF DISABILITY
SPOUSE	LAST NAME _____	FIRST NAME _____	DATE OF BIRTH (mm-dd-yyyy) _____	☐ M ☐ F	**N/A**
CHILD 1	LAST NAME _____	FIRST NAME _____	DATE OF BIRTH (mm-dd-yyyy) _____	☐ M ☐ F	☐ Full-time student _____ ☐ Disabled _____
CHILD 2	LAST NAME _____	FIRST NAME _____	DATE OF BIRTH (mm-dd-yyyy) _____	☐ M ☐ F	☐ Full-time student _____ ☐ Disabled _____
CHILD 3	LAST NAME _____	FIRST NAME _____	DATE OF BIRTH (mm-dd-yyyy) _____	☐ M ☐ F	☐ Full-time student _____ ☐ Disabled _____
CHILD 4	LAST NAME _____	FIRST NAME _____	DATE OF BIRTH (mm-dd-yyyy) _____	☐ M ☐ F	☐ Full-time student _____ ☐ Disabled _____

IMPORTANT: If you do not designate a beneficiary at the time of enrollment, the benefit will be payable to your estate.

SECTION E: BENEFICIARY DESIGNATION

*If you name multiple beneficiaries, the total allocation must be equal to 100%. These beneficiaries are revocable. Note: if any of your beneficiaries are under the age of majority, you **must** appoint them a trustee below.*

LAST NAME	FIRST NAME	RELATIONSHIP	DATE OF BIRTH (mm-dd-yyyy)	SHARE
				%
				%
				%

I appoint a revocable Trustee to receive any amount which may be due to my beneficiary, while such beneficiary is a minor:

TRUSTEE'S LAST NAME	TRUSTEE'S FIRST NAME

Member Initial:

SECTION F: EMPLOYEE CONFIRMATION

I AGREE to the conditions of the contract(s) between me, CDWA and the insurer(s) and authorize the CDWA to deduct required contributions, via pre-authorized debit. I understand benefits will be activated upon three months pre-payment.

I AUTHORIZE Benefits by Design Inc. and all insurers to exchange the information detailed in this application, and any other benefit related information contained in files regarding me or my dependents for the purposes of administration and/or management of the group insurance policies issued by the insurers

I UNDERSTAND that this original document and all other original documents pertaining to me and my dependents are in the property of Benefits by Design Inc. and will be permanently retained by Benefits by Design Inc. as required by the insurers.

I CONFIRM that the information I have provided is true and complete.

X _____ _____

AUTHORIZED SIGNATURE OF MEMBER DATE (mm-dd-yyyy)

SECTION G: DISCLOSURE

At Benefits by Design (BBD) Inc., the personal information we collect concerning you and your dependents is kept in strict confidence and is only used for purposes you have authorized. Your personal file will be kept at BBD's offices. You have the right to request access to your personal information and, if necessary, correct any inaccurate information. To do so, please contact your Plan Administrator at the CDWA. If you are unsure who your Plan Administrator is, contact BBD at 1-800-668-2295 (if you are located in British Columbia and Alberta) OR call 1-888-272-0413 (for all other provinces). Access to your personal information will be limited to employees, agents, reinsurers and service providers of BBD in the performance of their duties, individuals to whom you have granted access, and persons authorized by law. For the purposes of audits and administrative reporting, BBD may release your Member /Policyholder statistical financial information without personal identifiers.