OUR FLEX BENEFITS PROGRAM

Going Places Together.

RED RIVER COLLEGE OF APPLIED ARTS, SCIENCE AND TECHNOLOGY

ENROLMENT FORM

canada life

Policy No. 57353 – Flex Health, Dental & Health Spending Account
Policy No. 160733 – Global Medical Assistance

Enrolment Deadline: 2 weeks

EMPLOYEE INFORMATION

Surname:		Given Name and Middle Initial(s):	Employee Number:	
Birth Date (*month/day/year*):	Gender: ☐ *Male* ☐ *Female*	Home Telephone: ( )	Work Telephone: ( )	
Address:		City:	Province:	Postal Code:

DEPENDENT INFORMATION IF APPLICABLE - Employees must enroll according to their true dependent status.

True Dependent Status: ☐ *Single* *OR* ☐ *Family (having at least 1 dependent)*

SPOUSE

Surname (if different from Employee Surname):	**What group benefits coverage does your spouse have through his/her employer?** ***Where applicable, benefit payments will be coordinated between this plan and your spouse's plan.***				
Given Name and Middle Initial(s):	***Spousal Group Coverage***	***Single***	***Family***	***Waived***	***None***
☐ *Legally Married* ☐ *Common Law* If common law, please provide commencement date of cohabitation (*month/day/year*):	Health	☐	☐	☐	☐
	Drugs	☐	☐	☐	☐
Birth Date (*month/day/year*):	Vision	☐	☐	☐	☐
Gender: ☐ *Male* ☐ *Female*	Dental	☐	☐	☐	☐

UNMARRIED DEPENDENT CHILDREN (Please use back of this page if additional space required.)

Surname (if different from Employee Surname)	Given Name and Middle Initial(s)	Gender *Male*	Gender *Female*	Birth Date (*month/day/year*)	Full-time Student *Yes*	Full-time Student *No*	Disabled prior age 22 *Yes*	Disabled prior age 22 *No*
		☐	☐		☐	☐	☐	☐
		☐	☐		☐	☐	☐	☐
		☐	☐		☐	☐	☐	☐
		☐	☐		☐	☐	☐	☐
		☐	☐		☐	☐	☐	☐

FLEX PLAN SELECTION – Select one of the 5 Flex Options

Option (check one)	**1** ☐	**2** ☐	**3** ☐	**4** ☐	**5** ☐
Employee Annual Cost	No Cost	$199 single / $437 family	No Cost	No Cost	$599 Single / $1,317 Family
Employee Bi-Weekly Cost	No Cost	$7.65 single / $16.81 family	No Cost	No Cost	$23.04 Single / $50.65 Family

I hereby apply for coverage under the group benefits plan issued by Red River College. I authorize Red River College:

- To deduct from my pay the plan member contributions required under the plan, if applicable; and
- To exchange personal information, when necessary to determine my eligibility for coverage and to administer the plan.

If applying for coverage for my spouse and/or dependants, I confirm that I am authorized to act on their behalf. I agree that a photocopy or electronic copy of this application is as valid as the original. I certify that the information given is true, correct and complete to the best of my knowledge.

Employee Signature: _____ **Date *(month/day/year)*:** _____

Please submit completed form to:
Human Resource Services - Pay & Benefits Administration
C410-2055 Notre Dame Avenue, Winnipeg, MB, R3H 0J9
Telephone: 204-632-2319

OFFICE USE ONLY:

Div	Class	FT/PT	S/F

Eff Date: _____ *(month/day/year)* **Payroll Authorization:** _____