



# Enrolment Form Employee Benefits

## 1. Information to be completed by your employer

|   |   |                             |              |
|---|---|-----------------------------|--------------|
| First Name:   | Last Name:  | Date of Birth: (dd/mm/yyyy) | Benefit ID:  |
| Street Address:   | City:   | Province:                   | Postal Code: |
| Employment Type:<br><input type="checkbox"/> Permanent <input type="checkbox"/> Temporary                               | Date of Hire: (dd/mm/yyyy)  | Union Affiliation:          |              |
| Employee Type:<br><input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Casual |   |                             |              |
| Disability Plan Join Date:<br>(dd/mm/yyyy)  | Disability Plan:<br><input type="checkbox"/> CUPE <input type="checkbox"/> SEIU <input type="checkbox"/> SUN <input type="checkbox"/> General |                             |              |
| Group Life Plan Join Date:<br>(dd/mm/yyyy)  |   |                             |              |

|                       |                           |
|-----------------------|---------------------------|
| Employer Number:      | Employer Name:            |
| Contact Name:         | Contact Telephone Number: |
| Authorized Signature: | Date Signed: (dd/mm/yyyy) |

## 2. Spousal Information

Co-ordination of benefits information must be reported to the insurance provider. Please see the commentary booklets for contact information.

### Add or Change Spousal Information:

|  |   |                              |
|--|---|------------------------------|
| Spouse's First Name:   | Spouse's Last Name:                         | Date of Birth: (dd/mm/yyyy): |
| Common-law *: <input type="checkbox"/> Yes <input type="checkbox"/> No | Relationship Effective Date**: (dd/mm/yyyy) |                              |

\* A Common Law Spouse is a person with whom you have been cohabiting in a spousal relationship for at least one full year.

\*\* The Relationship Effective Date is the date you were legally married or the date you first began cohabiting as Common Law.

## 3. Dependent Information

### Add or Change Dependent Information:

| First Name | Last Name | Birth Date<br>(dd/mm/yyyy) | Dependent with a<br>Disability<br>(age 21 and over) | Over Age<br>Student<br>(age 21-25) |
|------------|-----------|----------------------------|---|------------------------------------|
|            |           |                            | <input type="checkbox"/>                            | <input type="checkbox"/>           |
|            |           |                            | <input type="checkbox"/>                            | <input type="checkbox"/>           |
|            |           |                            | <input type="checkbox"/>                            | <input type="checkbox"/>           |
|            |           |                            | <input type="checkbox"/>                            | <input type="checkbox"/>           |

Return the completed form to:

3sHealth Employee Benefits • 700-2002 Victoria Avenue • Regina, SK S4P 0R7 • T 1.866-278.2301 • ebp@3sHealth.ca • www.3sHealth.ca

#### 4. Group Life Insurance – Additional Coverage

##### Basic Life Insurance, Basic Accidental Death and Dismemberment (AD&D) and Dependent Life Insurance

Basic Life Insurance is payable to your named beneficiary in the event of your death. The amount payable is two (2) times your annual salary, rounded up to the next \$1,000 to a maximum of \$1,000,000. If you are age 65 or older, the amount payable is one (1) times your annual salary, rounded up to the next \$1,000 to a maximum of \$250,000.

Basic AD&D Insurance is payable to you in the event of a loss, or loss of use of: life, limb, sight, hearing or speech due to an accidental injury or in the event of your accidental death to your named beneficiary. The amount payable is a percentage of your basic life insurance and in event of your accidental death, your Basic AD&D Insurance amount is payable in addition to your Basic Life Insurance amount.

Dependent Life Insurance is payable to you in the event of the death of your eligible spouse and/or dependent(s). Dependent Life Insurance is a flat amount of \$10,000 for a spouse and \$5,000 per child. If you are eligible for Basic Life Insurance, Dependent Life Insurance is automatically included in your coverage. The monthly premium for Dependent Life Insurance is included in your Basic Life Insurance monthly premium amount.

You must name a beneficiary to ensure life insurance benefits are paid to the correct person(s). You may designate or change your beneficiary at any time by completing this form.

##### Optional Life Insurance - Maximum 50 units; 1 unit = \$10,000

Optional Life Insurance is payable to your named beneficiary in the event of your death. You may elect up to \$150,000 of Optional Life Insurance within the first 90 days of becoming eligible in the plan. Optional Life Insurance coverage in excess of \$150,000 or applied for after your first 90 days will require you to complete medical evidence of insurability and is subject to the approval of the insurer.

**Important Note: This election form must be received by the 90th day after Plan eligibility. No exceptions will be made. Full evidence of insurability is required for late applications.**

PLEASE DO NOT WRITE IN GREY AREAS - OFFICE USE ONLY

|                            | Optional Group Life<br>Non-Smoker | Optional Group Life<br>Smoker | Single Voluntary AD&D | Family Voluntary AD&D |
|----------------------------|-----------------------------------|-------------------------------|-----------------------|-----------------------|
| Current Coverage in Force: |                                   |                               |                       |                       |

- I hereby apply for Optional Life Insurance in the amount of \_\_\_\_\_ total units.
- I hereby apply to increase my Optional Life Insurance by \_\_\_\_\_ total units for a total of \_\_\_\_\_ units.
- I wish to reduce my Optional Life Insurance to \_\_\_\_\_ total units.
- I wish to cancel all of my Optional Life Insurance.

**Within the past 12 months have you smoked or used cigarettes, hashish, cigars, pipe, cigarillos, chewing tobacco, nicotine patch and or/gum, betel nuts, or tobacco or nicotine in any other form?**

- Yes
- No

##### Voluntary Accidental Death and Dismemberment (AD&D) - Maximum 25 units; 1 unit = \$10,000

Voluntary AD&D Insurance is payable to you in the event of a loss, or loss of use of: life, limb, sight, hearing or speech due to an accidental injury or in the event of your accidental death to your named beneficiary. You may elect to purchase Voluntary AD&D Insurance at any time after becoming eligible in the Plan without evidence of insurability.

- I hereby apply for Voluntary AD&D Insurance in the amount of \_\_\_\_\_ total units.
- I hereby apply to increase my Voluntary AD&D Insurance by \_\_\_\_\_ total units for a total of \_\_\_\_\_ units.
- I wish to reduce my Voluntary AD&D Insurance to \_\_\_\_\_ total units.
- I wish to cancel all of my Voluntary AD&D Insurance.

**Coverage Type - I elect Voluntary AD&D Insurance for:**

- Myself only.
- Myself and my eligible spouse and/or dependents.

The monthly premium rates for additional coverage are available on the 3sHealth website [www.3sHealth.ca](http://www.3sHealth.ca) or from your Employer. All premium amounts are payable by the Employee through payroll deductions. Additional coverage automatically terminates on the earliest of the date your employment ends or your 65th birthday.

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## 5. Group Life Insurance Beneficiary Designation

This beneficiary designation will replace all other beneficiary designations that you have made before, even if your beneficiary designation was made with another employer. Please ensure you are making a full and complete beneficiary designation that clearly states how you wish the policy proceeds to be disbursed in the event of your death.

### 1) Primary Beneficiary(ies):

Name the person(s) to receive the insurance benefit if you pass away while insured.

| First Name | Last Name | Relationship to You  | Date of Birth | % of Benefit<br>(Must Total 100%) |
|------------|-----------|--|---------------|-----------------------------------|
|            |           | <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Sibling<br><input type="checkbox"/> Friend <input type="checkbox"/> Estate <input type="checkbox"/> Other: _____ |               |                                   |
|            |           | <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Sibling<br><input type="checkbox"/> Friend <input type="checkbox"/> Estate <input type="checkbox"/> Other: _____ |               |                                   |
|            |           | <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Sibling<br><input type="checkbox"/> Friend <input type="checkbox"/> Estate <input type="checkbox"/> Other: _____ |               |                                   |
|            |           | <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Sibling<br><input type="checkbox"/> Friend <input type="checkbox"/> Estate <input type="checkbox"/> Other: _____ |               |                                   |

### 2) Contingent Beneficiary(ies):

If all of the persons above pass away before you, name a person(s) to receive the insurance benefit if you pass away while insured.

| First Name | Last Name | Relationship to You  | Date of Birth | % of Benefit<br>(Must Total 100%) |
|------------|-----------|--|---------------|-----------------------------------|
|            |           | <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Sibling<br><input type="checkbox"/> Friend <input type="checkbox"/> Estate <input type="checkbox"/> Other: _____ |               |                                   |
|            |           | <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Sibling<br><input type="checkbox"/> Friend <input type="checkbox"/> Estate <input type="checkbox"/> Other: _____ |               |                                   |
|            |           | <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Sibling<br><input type="checkbox"/> Friend <input type="checkbox"/> Estate <input type="checkbox"/> Other: _____ |               |                                   |
|            |           | <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Sibling<br><input type="checkbox"/> Friend <input type="checkbox"/> Estate <input type="checkbox"/> Other: _____ |               |                                   |

### 3) Trustee:

If any person(s) above are under 18; name a trustee who will receive and be responsible for the insurance benefit on the child's behalf.

| First Name | Last Name | Relationship to You  | Date of Birth |
|------------|-----------|--|---------------|
|            |           | <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Sibling<br><input type="checkbox"/> Friend <input type="checkbox"/> Estate <input type="checkbox"/> Other: _____ |               |

## Please sign and date below.

I hereby acknowledge that I have read and understand the conditions of the Employee Benefit Plans, as outlined in the Plans' commentaries available online at [www.3sHealth.ca](http://www.3sHealth.ca), and confirm the options I have chosen above. I understand these benefits are subject to the terms of the Group Life Insurance Plan, Disability Plan, Core Dental Plan, Enhanced Dental Plan and Extended Health Care Plan, as applicable, sponsored by Health Shared Services Saskatchewan.

I hereby expressly consent to the collection, use, and disclosure of my personal information by 3sHealth for the purpose of administering my benefits, for the purpose of sharing my information with future or replacement service providers relating to the administration of my benefits, and as otherwise provided in the 3sHealth Privacy Policy (available online at [www.3sHealth.ca](http://www.3sHealth.ca)). I further consent to 3sHealth using my personal information in other 3sHealth systems, including the payroll system, where required for the administration or payment of my benefits.

By signing here, I agree that the information provided is complete and accurate. I appoint the beneficiaries above to receive the Group Life Insurance benefit when I die. I understand that the beneficiaries named on this form replace all previous beneficiary declarations for my Group Life Insurance. I may change my beneficiary(ies) at any time upon written notice to 3sHealth.

|                 |                    |
|-----------------|--------------------|
| Your Signature: | Date: (dd/mm/yyyy) |
|-----------------|--------------------|

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## Designating a Beneficiary - Frequently Asked Questions

*One of the most important rights that an insured person has in a life insurance policy is the right to designate the beneficiary.*

### What is a beneficiary?

A beneficiary is the party or parties who will receive the policy proceeds from your 3sHealth Group Life Insurance coverage upon your passing. There are two kinds of beneficiaries:

1. *Primary Beneficiary* – is the person(s) who will receive the policy proceeds when you pass away.
2. *Contingent Beneficiary* – is the person(s) who will receive the proceeds if your Primary beneficiary passes away before you do.

### Who may I name as my Primary or Contingent beneficiary?

You may name any person as your beneficiary such as your spouse, parent, etc. You may designate more than one beneficiary. You may also name a legal entity as your beneficiary such as your estate or a charitable organization. If you choose to name a charitable organization as a beneficiary, the full legal name and address of the charitable organization is required.

### May I name my child(ren) as my beneficiary?

Yes, you may name your child(ren) as your beneficiary. If you name a minor child or children under the age of 18 as a Primary or Contingent beneficiary, you must appoint a Trustee. Upon your death, the Trustee will receive the policy proceeds and has a legal duty to use those proceeds for the benefits of the beneficiary. You will want to appoint someone who is capable of managing the policy proceeds wisely.

If you do not appoint a trustee, payment will go to the Public Trustee in the child's province of residence or to a court-appointed property guardian.

### How will the policy proceeds be divided if I designate more than one beneficiary?

When you designate your beneficiaries, you may indicate the portion (percentage) of the policy proceeds you would like to give to each of the named parties. If you do not detail a percentage of the benefit for each party, the policy proceeds will be divided equally among all of your named beneficiaries.

### What if I have not named a beneficiary?

If you do not name a beneficiary, or your beneficiaries are not living at the time of your death, the proceeds will be paid to your estate.

### Is it easier to leave the policy proceeds to my estate and have it dealt with in my will?

No, settling an estate can take from weeks to sometimes years, and it can be very costly. During the time it takes to settle your estate, the money within your estate is inaccessible. Designating a beneficiary is like taking a shortcut. Upon your death, the insurance carrier will pay the policy proceeds from your 3sHealth Group Life Insurance benefit directly to your named beneficiaries. It is a quick way of getting the money to your loved ones.

In addition, if you leave the policy proceeds from your 3sHealth Group Life Insurance benefits to a beneficiary, the money becomes his/her property and is safe from creditors, in case you should die while owing money. If the policy proceeds are left to your estate, the money could be made available to your creditors.

### How do I name my beneficiary or change my beneficiary?

When you become eligible for the 3sHealth Group Life Insurance Plan, you must complete an Enrolment Form which includes a section to designate your beneficiaries for your Group Life Insurance. To change your beneficiary, contact 3sHealth Employee Benefits for the appropriate form. Once complete, return the forms to 3sHealth Employee Benefits.

### Do I have to tell my beneficiaries I have named them?

No, your beneficiaries do not have to know that they have been named. But, after your death, 3sHealth must be able to find your beneficiaries in order to make the benefit payment. In order to avoid complications or unnecessary delays you should keep up-to-date address information for your beneficiaries in your personal files.

### What if I belong to the 3sHealth Group Life Insurance Plan with more than one participating member of the organization?

Each time you make a new beneficiary designation, it will replace all other beneficiary designations that you have made before, even if your beneficiary designation was made with another employer. Your new beneficiary designation must be a full and complete designation that clearly states how you wish the policy proceeds to be disbursed in the event of your death.

### How can I find out who my beneficiary is?

Upon your request, 3sHealth Employee Benefits can confirm your beneficiary designation. Additionally, once per year we will send you your Member's Annual Statement which will list your current beneficiaries.

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