The Construction Industry's Benefit Plan
Employee Enrolment Form

To complete this form online, please open it in Adobe

Section 1 – Employment Info - Employer complete this section

*Note: Words in **bold italics** are defined on page 3 and 4*

Organization/Company		***Company No.***	Check One: New Application / Reinstatement
Employee First Name	Employee Last Name		SIN No.
Occupation	***Date of employment*** (dd/mm/yyyy)		Regular hours worked per week
Your Name and Title	Email address		Phone No.
Date signed (dd/mm/yyyy)	Signature		

Section 2 – Employee/Family Information - Employee complete this section

Date of birth (dd/mm/yyyy)	***Gender*** Male Female X	***PharmaCare Registration No.*** A-	
Email address			Daytime phone number
Home address (unit, street address or PO BOX)	City	Province	Postal Code

Dependent Information **– complete this section if you have a spouse/eligible children** ❑ More than 4 children, attach list

	First Name	Last Name	Date of Birth (dd/mm/yyyy)	***Gender***	
Spouse				Male X Female	❑ Married ❑Common-Law* **Date of cohabitation (dd/mm/yyyy)*
					If over 21:
Child 1				Male X Female	❑ Full-time Student ❑ Disabled
Child 2				Male X Female	❑ Full-time Student ❑ Disabled
Child 3				Male X Female	❑ Full-time Student ❑ Disabled
Child 4				Male X Female	❑ Full-time Student ❑ Disabled

Section 3 – Coordination of Benefit Information

Complete this section if you or your dependents are covered by another EHC or Dental plan

- *This information is required to establish which plan is primary and which plan is secondary for your family's claims.*
- *Do not complete this section if your child(ren) are covered by the BC Healthy Kids program, as it is always the last payer and will not affect claims under your CIBP plan.*

Benefits covered by other plan: ❑ EHC ❑ Dental

Who is the cardholder of the other plan?

❑ My Spouse ***Spouse's birthday*** **(dd/mm)**

❑ My dependent child(ren)
(e.g. Student plan through university)

❑ Other (specify):

❑ My dependent child(ren)'s non-custodial parent
(applicable only if you are the custodial parent)

❑ My dependent child(ren)'s custodial parent
(applicable only if you are not the custodial parent)

❑ My dependent child(ren)'s parent/step-parent who has joint physical custody with me.
Parent/step-parent's birthday (dd/mm):

Insurance Company	Policy No.	Effective Date (dd/mm/yyyy)

Who is covered by this other plan? (Check all that apply)

❑ Myself ❑ My Spouse ❑ All my dependent children, or ❑ Child 1 ❑ Child 2 ❑ Child 3 ❑ Child 4 ❑ Child 5

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Section 4 – Employee complete this section

Beneficiary Designation for Basic Life and Basic Accidental Death insurance:

Primary Beneficiary(ies) To designate more than 3 primary beneficiaries, complete Beneficiary Designation form.

	Name	Relationship to You	*Type* Important: See note below	Percentage
1	First name Middle initial Last name		Revocable Irrevocable	%
2	First name Middle initial Last name		Revocable Irrevocable	%
3	First name Middle initial Last name		Revocable Irrevocable	%

If you designate a beneficiary as irrevocable, that person's consent is required if you later want to change your beneficiary. A minor child cannot give consent, therefore if you designate a minor child as irrevocable, you will not be able to change your beneficiary until the child reaches the age of majority and consents to the change.
The percentages must total 100%. If percentage is left blank, insurance will be split evenly among the beneficiary(ies). If you want to designate more than 3 primary beneficiaries, complete Beneficiary Designation form. If you do not designate a beneficiary, proceeds will be paid to your estate.

Trustee **(Complete if any beneficiary is under the age of majority.)**

I appoint ____ as Trustee to receive any amount due to any beneficiary under the age of majority.

Contingent Beneficiary **(Optional):**	Name First name Middle initial Last name	Relationship to You

Section 5 – Personal Information Release - Employee complete this section

Please list any individuals that you would like to have access to your personal information under the Plan. Personal information includes but is not limited to: ID number, beneficiary information and claims information.

First Name	Last Name	Relationship to You
First Name	Last Name	Relationship to You
First Name	Last Name	Relationship to You

Section 6 – Declaration and Authorization - Employee complete this section

Protecting your personal information
ICBA Benefits is committed to protecting the privacy, confidentiality, accuracy and security of your personal information. Your and your spouse or dependent's personal information may be shared with the insurance company and its reinsurers, your employer, health services providers, and/or administrators of government benefits or other benefits programs for the purposes of verifying eligibility for specific benefits or claims and/or investigating or reporting upon suspected or apparent fraudulent or repeated inaccurate claims behaviour.
ICBA Benefits is compliant with Canadian and provincial privacy legislation. Please see our website for our complete Privacy Policy.

Declaration and authorization
I hereby apply for coverage under this policy, and accept its terms and conditions. I authorize the necessary contributions to be made through payroll deductions, if applicable. I authorize my employer and ICBA Benefits, the insurance company and its reinsurers, any healthcare provider, administrators of government benefits or other benefits programs to give, receive and share any personal information regarding my eligibility for coverage and to administer the plan, or those of my dependents, if applicable.

I understand that I am responsible for the accuracy of all claims submitted on behalf of myself, my spouse and/or dependents, and that my eligibility and/or entitlement to any or all benefits under the Plan may be suspended and/or revoked without notice in the event that I or my spouse or dependents am found to have made fraudulent or repeated inaccurate claims under the Plan. Further, I hereby authorize my Employer to deduct from my payroll and remit to the Plan any amounts paid to me as a result of fraudulent or inaccurate claims by myself, my spouse or my dependents.

I certify that I am covered, and my spouse and children (if applying for coverage) are covered by a provincial medical plan, e.g. Medical Services Plan of BC.

I certify that all of the information I have provided on this form is true, correct and complete to the best of my knowledge.

Signature:	Date Signed (dd/mm/yyyy):

Return completed form to ICBA Benefits via email (indicate the policy number in the Subject line), or by mail.
If you email the form, do not also send the original by mail.

ICBA Benefit Services Ltd. | Email: benefits@mycibp.ca | Mailing Address: 700-4730 Kingsway, Burnaby, B.C. V5H 0C6

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Instructions/Additional Information:

Coordination of Benefit Information - This information is required to establish which plan is primary and which plan is secondary for EHC and Dental claims. When a claimant is covered by more than one plan for EHC or Dental, insurance companies follow guidelines set out by the Canadian Life & Health Insurance Association (CLHIA) to determine which plan pays first, known as the primary plan. If the primary plan does not cover the entire expense, the unpaid balance is then submitted to the secondary plan for payment. For more information, see CLHIA's Coordination of Benefit guidelines, which are available to the public on CLHIA's website.

Contingent Beneficiary – If all the primary beneficiaries should die before you, proceeds will be paid to a contingent beneficiary. Should there not be any surviving beneficiaries at the time of your death, the proceeds will be paid to your estate.

Gender – Please indicate the gender on your government issued ID. For gender X, write "X". Note: the insurance company may require a gender of male or female for underwriting purposes.

If over 21 - To be covered on your plan beyond age 21, a child must either meet Canada Revenue Agency's criteria for a full-time student, or be disabled. If your child is disabled, additional information is required to approve coverage beyond the plan's age limits. Contact us for more information.

Primary Beneficiary - If you designate a beneficiary as irrevocable, that person's consent is required if you later want to change your beneficiary. The percentages must total 100%. If percentage is left blank, insurance will be split evenly among the beneficiary(ies). If you want to designate more than 3 primary beneficiaries, complete Beneficiary Designation form. If you do not designate a beneficiary, proceeds will be paid to your estate.

Reinstatement – If the employee previously had coverage under the plan and coverage terminated more than 6 months from the date of rehire, the plan waiting period will be applied to the date of rehire (unless you indicate that you are waiving the waiting period). If the previous coverage terminated less than 6 months from the date of rehire, coverage starts on the date of rehire. Note, both situations are subject to late application rules.

Spouse's Birthday – Why do we need to know your spouse's birthday? If you've listed your spouse in section 2 of this form, you don't have to provide their birthday again here. Otherwise, this is needed to establish which plan is primary and which is secondary. Where the child lives with both parents, the plan of the parent with the birthday that occurs earliest in the year (regardless of age) is the primary plan.

Trustee - Designate a trustee for any beneficiary who is younger than the age of majority in your province.

Type – If you designate a beneficiary as Irrevocable, you cannot change your beneficiary designation without that person's consent. Important note: If you designate a minor child as your Irrevocable beneficiary, the child cannot consent to a change in beneficiary until they reach the age of majority. If you designate your beneficiary as Revocable, you may change your beneficiary designation at any time without restriction.

PharmaCare Registration Number – Under the CIBP drug plan, if the insurance company does not have confirmation that you are registered with BC Fair Pharmacare, it will suspend claims payments when your family's claims reach a certain threshold each year. To avoid disruption in your claims under your drug plan, provide your PharmaCare registration number.
Note: This is not a mandatory field.

Do not return this page to ICBA Benefits.