Hospitality Benefits Enrollment Form

the benefits trust

Reset Form

Part A: Employee to complete

Personal Information

Sex:

Last Name: _____ First Name: _____ ☐ M ☐ F

Address: _____ Apt. # _____

City: _____ Province: _____ Postal Code: _____

Date of Birth: (Month) ____ (Day) ____ (Year) _____ Personal Email: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Common Law Length of C/L Relationship: _____

Direct Deposit: Please provide direct deposit information (page 3)

Dependant Information

Please list all dependants including your spouse, common-law spouse (relationship of at least one year), and/or children. Refer to your benefits booklet or ask your employer to confirm who is considered an eligible dependant. Complete an "**Overage Dependant**" form if applicable.

			Date of Birth (Month)	(Day)	(Year)
Spouse's Last Name	First Name				
_____	_____	☐ M ☐ F	_____ /	_____ /	_____
Child's Last Name	First Name		(Month)	(Day)	(Year)
1. _____	_____	☐ M ☐ F	_____ /	_____ /	_____
2. _____	_____	☐ M ☐ F	_____ /	_____ /	_____
3. _____	_____	☐ M ☐ F	_____ /	_____ /	_____
4. _____	_____	☐ M ☐ F	_____ /	_____ /	_____

Selection of Coverage

Please indicate Single coverage (for yourself only or Family coverage (for yourself and your dependants)

Health and Dental Benefits: ☐ Single ☐ Family

Does your **spouse** have benefits coverage through his/her employer's plan? ☐ No ☐ Yes If Yes: ☐ Single ☐ Family

Provide the name of your Spouse's Employer and Insurance Company below:

Spouse's Employer: _____ Insurance Company: _____

Revocable Beneficiary Designation

If your beneficiary is a child under age 18, you must also complete a "**Declaration Appointing Trustee**" form. If you make any changes or corrections in this section, you must initial the change or correction.

Beneficiary's Last Name	First Name	Relationship (e.g. spouse, child)	Age (If a child)
_____	_____	_____	_____

For Quebec residents: the appointment of a spouse as Beneficiary is considered "IRREVOCABLE" unless the word "REVOCABLE" is written after the spouse's name.

Employee Authorization

I hereby apply for the benefits for which I am or may become eligible, subject to any waiver indicated, under the Benefit Services Contract issued by The Benefits Trust and authorize that any required contributions be deducted from my earnings. In addition, I authorize The Benefits Trust and its administrators to use my social insurance number, if applicable, for identification purposes in the administration of the Benefit Services Contract. On behalf of myself and my dependents, I also authorize The Benefits Trust (including its affiliates and/or insurance partners) to exchange the information detailed in this Enrollment and any other benefit related information contained in files regarding me or my dependents, now or in the future, for the purposes of administration and/or management of the Benefit Services Contract issued by The Benefits Trust.

Employee Signature: _____ Date: (Month) _____ (Day) _____ (Year) _____

Restaurant Franchisee Benefits Enrollment Form

the benefits trust

Part B: Employer to complete

Instructions to Employer:

1. Before submitting this application to The Benefits Trust please ensure that it has been completed fully. An incomplete form will delay the employee's enrollment in the benefits plan.
2. This application **must be** received by The Benefits Trust **within 31 days** of the employee becoming eligible to join the benefits plan. If the application is received after such time, the applicant will be treated as a **LATE ENTRANT** and may be required to submit evidence of insurability to be eligible for benefits coverage.

Contractholder Information

Name of Employer _____ Group / Policy Number _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Employee Coverage and Eligibility Information

Benefit Class ☐ Gold ☐ Silver ☐ Bronze

Date Employed on a Full-time Basis: (Month) _____ (Day) _____ (Year) _____

Date Coverage To Begin: (Month) _____ (Day) _____ (Year) _____

Employer Comments

Please note any exceptions or other comments (e.g. waive normal waiting period requirement; or special terms of employment contract which could affect benefits coverage)

Employer Authorization

Authorized Signature: _____ Date: (Month) _____ (Day) _____ (Year) _____

FOR INTERNAL USE ONLY

THE BENEFITS TRUST is administered by:

The Benefits Trust Inc.
3800 Steeles Avenue West, Suite 102W, Vaughan, Ontario L4L 4G9

Phone: 416-498-7723 or 905-264-8990 Fax: 905-264-1123
Toll Free: 1-800-487-2993

Claims Direct Deposit Authorization Form
(Electronic Funds Transfer)

Claims payments from The Benefits Trust are deposited directly to your bank account. Explanations of benefits will be sent by email to the address provided on this form. **Please print clearly.** To set up this convenient process, complete this form and return it with a "void" cheque or a direct deposit printout from your financial institution to The Benefits Trust.

Employee Information

Employee Name (as shown for banking purposes):

_____

Employee Email: _____

Employer Name: _____

Contract or Group No: _____ Certificate No: _____

Attach "void" cheque or direct deposit printout from your financial institution.

I authorize The Benefits Trust to deposit all future claims payments directly to the account shown on the attached "void" cheque or direct deposit printout from my financial institution. I understand that any change to this authorization must be submitted in writing.

Signature (Type Full Name): _____ Date: _____

Return the completed form by mail, email, or fax with a "void" cheque or direct deposit printout from your financial institution. Please contact our office with questions.

The Benefits Trust
3800 Steeles Avenue West, Suite 102W
Vaughan, Ontario L4L 4G9

Phone: 905-264-8990
Toll Free: 800-487-2993

Fax: 905-264-1123
Email: claims@thebenefitstrust.com

For internal use only

EFT Processed: _____