Employee Enrolment Form

3075 Fourteenth Avenue, Suite 221, Unionville, ON L3R 0G9 T 905-946-8444 F 905-946-8944 info@ombas.ca www.ombas.ca

A Private Health Services Plan as defined in S.248(1) of the Income Tax Act

Section 1 — To be Completed by Employee

Full Legal Name of Company

Last Name Initial First Name

Job Title

Address

City Province Postal Code

Phone ( ) Fax ( )

Email

Date of Birth (YYYY MM DD) S.I.N.

Gender
- ☐ Male
- ☐ Female

Dependants
- ☐ Yes
- ☐ No

Marital Status
- ☐ Single
- ☐ Married
- ☐ Widowed
- ☐ Separated
- ☐ Divorced
- ☐ Common-Law

Dependant Information (spouse and eligible dependants to be covered)
If there are more dependants, please attach a separate listing.

Last Name	First Name	Relationship (Spouse/Child)	Date of Birth yyyy/mm/dd	Male	Female

Is your spouse insured under their employer's group insurance plan (required in the event of co-ordination of benefits) ☐ Yes ☐ No

If yes, please provide name of spouse's insurance company? ____________________

Coverage type (family/single) ____________________

I understand that if I am no longer employed FULL TIME at ____________________ and still have claims to submit, then I will submit claims directly to ____________________ within 10 business days of my last day of employment. I also understand that those claims must pre-date my final day of employment with ____________________.

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I hereby authorize Optimal Medical Benefit Administrative Services Limited to use my Social Insurance Number (S.I.N.) only when it is used for record keeping and certificate identification purposes.

S.I.N. ____________

I authorize Optimal Medical Benefit Administrative Services Limited to release to my employer any statistical information regarding claims paid on behalf of me, and my eligible dependants, other than specific details relating to a medical condition.

I authorize Optimal Medical Benefit Administrative Services Limited to maintain an enrolment card file and claim files as deemed necessary.

Date ____________ Employee Signature ____________

Section 2 — To be Completed by Employer

Annual Expenditure Limit $ ____________

Employee Classification ____________

Date Employed Full Time ____ YYYY ____ MM ____ DD

Hours Per Week ____________

Salary $ ____________

Commission $ ____________

I confirm that the above employee and the list of dependants are eligible for participation in the OMBAS Health Plan Contract dated ____________ , pro-rated from the date of enrolment to contract expiry.

In accordance with the contract I authorize the medical expenditure limit of ____________ for the above noted employee and dependants.

Date ____________ Employer Signature ____________

Section 3 — To be Completed as Waiver of Coverage/Refusal of All Benefits

In respect of total refusal of any coverage under this plan, I acknowledge that I have been offered the benefits of my employer's plan with Optimal Medical Benefit Administrative Services Limited and the benefits provided by this plan have been fully explained to me. I further acknowledge that I am forfeiting (as indicated below) all my rights and privileges in respect to such benefits. I understand that if I apply for refused coverage in the future, I may be requested to provide evidence of insurability at my own expense.

I waive total coverage for me and my dependants, if any.

Date ____________ Employee Signature ____________

In respect of refusal of coverage under this plan, I have fully explained the rights the employee is forfeiting, as indicated above.

Date ____________ Employer Signature ____________