STRIVE
INSURE

COST PLUS
ENROLMENT / CHANGE FORM

Employer / Plan Section (to be completed by the plan administrator)

Company Name: _____ Division: _____ Policy No: _____

❑ **New Plan Member** **Date of Hire** **(mmm/dd/yyy):** _____	❑ **Add Dependant:** **Effective date of coverage** **(mmm/dd/yyy):** _____
❑ **Effective date of coverage** **(mmm/dd/yyy):** _____	❑ **Terminate Dependant** **Termination date** **(mmm/dd/yyy):** _____
❑ **Terminate Plan Member** **Termination date** **(mmm/dd/yyy):** _____	❑ **Change Address**

Plan Member / Participant Details (to be completed by the employee)

Last Name: _____ First Name: _____ M/F: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Date of Birth: (mmm/dd/yyy): _____

Daytime Phone Number: _____ Email: _____

Coverage Status: Single: _____ Couple: _____ Family: _____ Waived: _____

Dependant Details (to be completed by the Plan Member)

(mmm/dd/yyy)

Spouse: Last Name: _____ First: _____ Sex: _____ DOB: _____

Child 1: Last Name: _____ First: _____ Sex: _____ DOB: _____

Child 2: Last Name: _____ First: _____ Sex: _____ DOB: _____

Child 3: Last Name: _____ First: _____ Sex: _____ DOB: _____

Child 4: Last Name: _____ First: _____ Sex: _____ DOB: _____

Child 5: Last Name: _____ First: _____ Sex: _____ DOB: _____

Please indicate the name of any disabled dependants: _____

Please indicate below if dependants are full time students and over age 21.

Attach the registration letter, which confirms full-time enrolment.

Name of Over Age Student	College/University Attended	Enrolled From	Enrolled To

***Complete page 2 of this form, in its entirety.**

Electronic Funds Transfer

Branch Transit Number (5 digits):_____

Bank Code (3 digits):_____

Account Number:_____

Bank Name:_____

Signature (to be completed by the Plan Member)

By enrolling in this plan, I am authorizing the applicable insurance carriers, agents and service providers to use and exchange information collected in this form to underwrite, administer and adjudicate claims. I also authorize my plan sponsor to use this same information for benefits administration and to make any necessary payroll deductions, which may be required.

I understand that in the event of termination of employment or voluntary termination of plan participation I will not receive a refund of any unused Health Spending Account contributions.

Plan Member / Subscriber Signature:_____

Employee / Subscriber Name (Please Print):_____

Date:_____

For Plan Administrator Use

- ❑ Keep the original form for your records.