Canadian HealthCare Administrators Inc.

For Corporations and Professionals

Employee Enrollment Form

Employer: ______________________________

To enroll in the Plan, **Please Complete Section One** and have **Your Employer Complete Section Two**.

Section One

Employee Name: (Please Print) ______________________________

Street Address: ______________________________ **City:** ____________ **Prov:** ________

Home Phone: (   ) ______________ **Date of Birth: (dd/mm/yy)** ______________ **PC:** ________

Listing of Dependents: List all of your dependents that will be covered under the Plan. (Attach separate listings if required)

	Name of Dependent	Relationship	Birth Date (dd/mm/yy)
1			
2			
3			
4			
5			
6			
7			
8			

Dependents of an Eligible Employee are defined as follows:

Any member of the employee's household with whom the employee is connected by blood relationship, marriage, common law relationship or adoption.

I wish to participate in the Employment Health Care Plan and confirm that the information above is correct.

Employee Signature: ______________________________ **Date: (dd/mm/yy)** ______________________________

Section Two - Employer Approval

I hereby confirm that the Employee mentioned above is an eligible employee.

Authorized Employer Signature: ______________________________ **Date: (dd/mm/yy)** ______________________________

Employee Classification:

1. Executive ☐ 2. Sr. Management ☐ 3. Full-Time ☐ 4. Part-Time ☐ 5. Commission ☐ 6. Other ☐