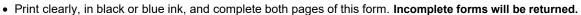
Health Benefits Trust Fund (HBTF) Plan

Medical Office Staff Enrollment Form



- Sign and date the form on the reverse and forward it to Doctors of BC at insurance@doctorsofbc.ca or fax to 604-639-2909.
- The applicant (and dependents) must be covered under a Provincial Health Care Plan (ie BC MSP) to be eligible to participate in this plan.
- Retain a photocopy for your files. IMPORTANT: The original Enrollment Form will be required in the event of a Life Insurance claim.

At Doctors of BC, we know that confidentiality of personal information is important. Go to https://www.doctorsofbc.ca/privacy-policy to view Doctors of BC's

Privacy Policy. By partie	cipating in this P	lan, you authorize Do	octors of BC and its	insurers to use the in	formation collected	on this form for ben	efits administration				
	Personal Information All applicants must be under age				First Name	Middle Initial					
65 at the time of application. Plan details and changes will be sent to you via your provided Preferred Email Address. *Spouse Email Address is required in the event that Evidence of Insurability applies.		Date of Birth		Employment (or date 20 hours per week)	Occupation						
		mm dd y Preferred Email Ad	yyyy mm dress	dd yyyy Gender:	Spouse Email Address*						
2. Group Life / A	D&D	Select the Grou	p Life/AD&D be	nefit you wish to	apply for (selec	t one):					
Crossed off beneficiary designations must be initialed or request a Change of Beneficiary form from the HBTF Plan Administrator. Physicians are NOT eligible for this benefit.		□\$20,000 □\$50,000									
		Designated Beneficiary(ies) – In the event of my death, I name the person(s) below to receive the policy proceeds. To the extent permitted by Law, I reserve the right to change the beneficiary(ies) named below:									
		Last Name	, ,	First Name		Relationship to You Per					
Beneficiary designation 100% and cannot be											
3. Long Term Disability		employee to comple Taxable monthly benefit: (check one only)	penefit amount you tete an Evidence of I	wish to apply for. (<i>Plensurability form and be</i>	ease Note: Covera		ge will be effective. eted should not				
		Gross Monthly Ear	nings								
4. Extended Heal Dental Depende Information		Your legal spaces your spourage	oouse, or a perso ise.	as any person who	ave lived for one y						
Check if apply coverage only (no		an educatior		ild(ren) under age 2 gnized by the Cana							
To waive this coverage coverage, complete Sec		If applying for depe	endent coverage, co	omplete the section be to proof of good heal	th if application is m	ade at a later date.					
First Name		Initial	Last Name	Gender (s	Relationship pouse/son/daughter		of Birth yyyy				
Spouse				☐ Male ☐ Female							
Child				☐ Male ☐ Female							
Child				☐ Male ☐ Female							
Child				☐ Male ☐ Female							

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	rirst Name	financial support; ple spaces provided. Name o		ution recognized by				ie CRA beli	g attended in	
5.	Refusal of Benefits Complete this section if you wish to refuse Extended Health Care and	I refuse Extended Health and Dental coverage as I and/or my dependents are insured under my spouse's group policy.								
	Dental Care for yourself and/or	For (check one		(: f ()						
	your dependent(s). This will be	☐ Myself and my dependent(s) (if any) ☐ My dependent(s) ONLY								
	allowed only if similar benefits are currently in force under your	🗀 му ферепо								
	spouse's group policy.	Current Insurer			Policy Number	Effective Date of Coverage				
	If you wish to add this coverage at									
	a later date, satisfactory proof of good health for you and/or your						mm	dd	уууу	
	dependent(s) may be required.	for coverage u make applicati	nder this Plan with	in 90 days of loss o you and/or your eli	erage terminates unde of such coverage withougible dependents will	ut proo	f of good h	ealth. If yo	ou do not	
_		I am authorize	ed to disclose infor	mation about my sp	ouse and dependents	in orde	r to enroll t	hem in the	plan.	
6.	Applicant Signature	By enrolling in this Plan, I authorize the following:								
	(<u>Must</u> be completed by ALL Applicants)	Canada Life Assurance Company ("Canada Life"), its agents and service providers its re-insurers and their service providers to collect, use and disclose relevant information about me to underwrite, administer and adjudicate claims, my plan sponsor and its agents and Doctors of BC to use the information collected in this for benefits administration and to make any necessary payroll deductions which may be required; Canada L agents and service providers and my plan sponsor and its agents to collect, use and disclose information ab me, my spouse and dependents necessary for enrollment and purposes of continuing administration of the placetime that the information above is accurate and true.							er and ed in this forr anada Life, i nation about	
			Appl	licant's Signature			mm	dd	уууу	
7.	To be completed by Physician/Employer	Name of Physician or Employer: HBTF Business ID								
	J 1 J -									
	(<u>Must</u> be completed by the sponsoring Member)	Address:								
	(<u>Must</u> be completed by the	Address:				Prov	rince	Postal (
	(Must be completed by the sponsoring Member) If you are a self-employed physician, you may name yourself		Area Code	Number	Fax Number:		rince	Postal (
	(Must be completed by the sponsoring Member) If you are a self-employed physician, you may name yourself	City Telephone Number:				Area	a Code	Number	-	
	(Must be completed by the sponsoring Member) If you are a self-employed physician, you may name yourself	City Telephone Number: I confirm that per week. I understand to	the Medical Off	fice Staff Applica	Number: ant is actively work ely working on the otify the HBTF Plan	Area	the offic	Number e 20 hou	rs or more	
	(Must be completed by the sponsoring Member) If you are a self-employed physician, you may name yourself	City Telephone Number: I confirm that per week. I understand to	the Medical Off	fice Staff Applications and is not active sponsibility to no	Number: ant is actively work ely working on the otify the HBTF Plan	Area	the offic	Number e 20 hou	rs or more	