canopy *health* insurance

MEMBER ENROLMENT FORM

PLEASE USE BLOCK LETTERS, TYPE OR PRINT WHEN COMPLETING THIS FORM

COMPANY INFORMATION (TO BE COMPLETED BY EMPLOYER)

GROUP NUMBER/ACCOUNT/DIVISION NUMBER

EMPLOYER/COMPANY NAME

LOCATION

EMPLOYMENT DATE (D D M M M Y Y)

EFFECTIVE DATE OF COVERAGE (D D M M M Y Y)

NEW HIRE (Y N)

REMARKS

EMPLOYEE PERSONAL INFORMATION (TO BE COMPLETED BY EMPLOYEE)

FIRST NAME

MI

LAST NAME

DATE OF BIRTH (D D M M M Y Y)

GENDER (M F)

OCCUPATION

MARITAL STATUS (MA SI DI WI SE CO)
MA-MARRIED; **SI**-SINGLE; **DI**-DIVORCED; **WI**-WIDOWED; **SE**-SEPARATED; **CO**-COMMON LAW

TRN (MEMBER)

CELL NO

HOME ADDRESS

EMAIL ADDRESS

GROUP *health* (TO BE COMPLETED BY EMPLOYEE)

DEPENDENTS

LAST NAME	FIRST NAME	MI	GENDER	RELATIONSHIP	DATE OF BIRTH	TRN
			M F		D D M M M Y Y	
			M F		D D M M M Y Y	
			M F		D D M M M Y Y	
			M F		D D M M M Y Y	

PROOF OF AGE FOR DEPENDENTS

☐ BIRTH CERTIFICATE ☐ OTHER SPECIFY

GROUP *life* (TO BE COMPLETED BY EMPLOYEE)

SALARY Weekly ☐ Fortnightly ☐ Monthly ☐ Annually ☐ $

BENEFICIARY NAME	RELATIONSHIP	LIFE%	DATE OF BIRTH	GENDER	TRN
			D D M M M Y Y	M F	
Trustee Name			Trustee TRN		
			D D M M M Y Y	M F	
Trustee Name			Trustee TRN		
			D D M M M Y Y	M F	
Trustee Name			Trustee TRN		
			D D M M M Y Y	M F	
Trustee Name			Trustee TRN		

BANKING INFORMATION (TO BE COMPLETED BY EMPLOYEE)

Bank Name

Bank Branch

Account Name

Account Type ☐ Savings ☐ Chequing

Account Number

As provided under my Employer's Group Contract with Canopy Insurance Limited, I elect coverage on behalf of myself and my eligible dependent(s) as listed overleaf (where applicable) and authorize my employer to deduct from my earnings the contributions required (if any) for the coverage.
I authorize Canopy Insurance Limited to have access to , and copies of, all medical, hospital or other institution/agency records relating to the diagnosis,treatment or service provided to me or a covered dependent.

COMPANY STAMP

SIGNATURE OF EMPLOYEE

DATE

NAME OF AUTHORIZED OFFICER OF EMPLOYER

POSITION OF AUTHORIZED OFFICER OF EMPLOYER

SIGNATURE OF AUTHORIZED OFFICER OF EMPLOYER

DATE

HEALTH HISTORY QUESTIONNAIRE

(IF EMPLOYEE IS APPLYING FOR COVERAGE OUTSIDE OF ELIGIBILITY PERIOD, PLEASE COMPLETE THE HEALTH HISTORY QUESTIONNAIRE)

THIS HEALTH HISTORY QUESTIONNAIRE IS BEING COMPLETED FOR: ☐ Employee Only ☐ Employee & Dependents ☐ Dependent(s) only

NAME	HEIGHT	WEIGHT	GENDER	RELATIONSHIP	DATE OF BIRTH	TRN
			M F		D D M M M Y Y	
			M F		D D M M M Y Y	
			M F		D D M M M Y Y	
			M F		D D M M M Y Y	

PERSONAL HEALTH HISTORY

(NOTE: IF QUESTIONNAIRE IS BEING COMPLETED FOR NEW DEPENDENTS, GIVE DETAILS ONLY FOR DEPENDENTS)

FOR THE EMPLOYEE

		YES	NO
1.	Are you employed by the employer named on this form for more than 30 hours per week?	☐	☐

FOR THE EMPLOYEE AND/OR DEPENDENTS KINDLY RESPOND 'YES' OR 'NO' TO THE FOLLOWING QUESTIONS.

2.	During the last 5 years, have you or any of your dependents consulted, been examined or treated by a Doctor, or been advised to have any diagnostic tests (e.g. blood tests, X-Rays, CAT Scan, MRI) etc.?	☐	☐
3.	During the last 5 years, have you or any of your dependents undergone a surgical operation, or been treated in any hospital or other institution?	☐	☐
4.	Have you or any of your dependents been treated for, or been told that you have Heart Trouble, Blood Disease, High Blood Pressure, Kidney Disorder, Diabetes, Tuberculosis, Cancer, Tumour, Ulcer, Asthma, Epilepsy, Alcoholism, Mental Disorder, or any other disease not listed anywhere on this application?	☐	☐
5.	Have you or any of your dependents been diagnosed with, or treated for HIV, AIDS, or ARC (AIDS related complications) (If 'Yes', underline disease.)	☐	☐
6.	Are you or any of your dependents now receiving, contemplating, or been advised to seek any medical attention or surgical treatment, or taking any medication?	☐	☐
7.	Do you or any of your dependents have any disorder of the female organs or breast?	☐	☐
8.	Are you or any of your dependents now pregnant?	☐	☐
9.	Do you or any of your dependents have any physical impairments?	☐	☐
10.	Do you or any of your dependents have any prior or existing history of alcoholism or drug abuse?	☐	☐
11.	Have you or any of your dependents ever had an application for Life or Health Insurance declined, postponed, rated or modified in any way?	☐	☐

IF THE RESPONSE TO ANY OF QUESTIONS 2-11 IS 'YES', GIVE COMPLETE DETAILS BELOW (CONTINUE ON ANOTHER SHEET, IF NECESSARY)

QUESTION NO.	FULL NAME OF PERSON TREATED	NATURE OF AILMENT	DEGREE OF RECOVERY: (FULL, PARTIAL OR CONTINUING)	NAME AND ADDRESS OF ATTENDING MEDICAL PROFESSIONAL	DATE OF VISIT

I declare that all the statements on this form are full, true and complete, and I understand that they form the basis upon which any insurance will be made effective. I authorize the physician, hospital or other medically related facility to disclose to Canopy Insurance Limited information about my health, habits or medical history, as well as that of any dependents listed above. It is further understood that Canopy Insurance Limited reserves the right to request an examination by a Physician of their choice to aid its decision.

SIGNATURE OF EMPLOYEE

DATE

TO BE COMPLETED BY EMPLOYER (IF APPLICABLE)

		YES	NO	If YES give detail
1.	Is the employee absent from work and unable to perform his/her duties?	☐	☐	
2.	Has the employee been absent from work for more than 1 week due to sickness or injury during the past 6 months?	☐	☐	
3.	Do you know of any prior or existing serious physical impairment, history of drug abuse or alcoholism?	☐	☐	

NAME OF AUTHORIZED OFFICER OF EMPLOYER

SIGNATURE OF AUTHORIZED OFFICER OF EMPLOYER

POSITION OF AUTHORIZED OFFICER OF EMPLOYER

DATE