03/21

Health Benefits Trust Fund (HBTF) Plan

Physician Enrollment Form

- Print clearly, in black or blue ink, and complete both pages of this form. **Incomplete forms will be returned.**
- Sign and date the form on the reverse and forward it to Doctors of BC at the address below.
- 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 participating in this Plan, you authorize Doctors of BC and its insurers to use the information collected on this form for benefits administration.

1. Personal Information

All applicants must be under age 65 at the time of application.
Plan details and changes will be sent to you via your provided Preferred Email Address.

Last Name | First Name | Middle Initial

Date of Birth | Preferred Email Address | Gender: ☐ Male ☐ Female

2. Extended Health/Dental Dependent Information

☐ Check if applying for single coverage only (no dependents).

If you wish to refuse this coverage, complete Section 5 on reverse.

An "eligible dependent" is defined as any person who is:

- Your legal spouse, or a person with whom you have lived for one year and have publicly represented as your spouse.
- Your unmarried dependent child(ren) under age 22, or under age 25 if a full-time student attending an educational institution recognized by the Canada Revenue Agency (CRA) and entirely dependent on you for financial support.

If applying for dependent coverage, complete the section below (attach a separate sheet if necessary).
Dependent(s) not listed will be subject to proof of good health if application is made at a later date.

First Name	Initial	Last Name	Gender	Relationship (spouse/son/daughter)	Date of Birth mm dd yyyy
Spouse			☐ Male ☐ Female		
Child			☐ Male ☐ Female		
Child			☐ Male ☐ Female		
Child			☐ Male ☐ Female		

If any of the above dependent children are full-time students age 22 or over but under the age of 25, and entirely dependent on you for financial support; please indicate below the name of the student and the educational institution recognized by the CRA being attended in the spaces provided.

First Name	Name of educational institution recognized by the CRA

3 . Refusal of Benefits

Complete this section if you wish to refuse Extended Health Care and Dental Care for yourself and/or your dependent(s). **This will be allowed only if similar benefits are currently in force under your spouse's group policy.**

If you wish to add this coverage at a later date, satisfactory proof of good health for you and/or your dependent(s) may be required.

I refuse Extended Health and Dental coverage as I and/or my dependents are insured under my spouse's group policy.

For (check one only):

☐ Myself and my dependent(s) (if any)
☐ My dependent(s) ONLY

Current Insurer | Policy Number | Effective Date of Coverage mm dd yyyy

I understand that if my and/or my dependent(s)' coverage terminates under the policy indicated above, I can apply for coverage under this Plan within 90 days of loss of such coverage without proof of good health. If you do not make application within 90 days, you and/or your eligible dependents will be required to provide proof of insurability acceptable to carrier to be covered.

4. Applicant Signature

If you are a self-employed physician, you may name yourself or your Corporation as Employer)

I am authorized to disclose information about my spouse and dependents in order to enroll them in the plan.

By enrolling in this Plan, I authorize the following:

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 form for benefits administration and to make any necessary payroll deductions which may be required; Canada Life, its agents and service providers and my plan sponsor and its agents to collect, use and disclose information about me, my spouse and dependents necessary for enrollment and purposes of continuing administration of the plan.

I declare that the information above is accurate and true.

Name of Physician or Employer:			HBTF Business ID
Address:			
City	Province	Postal Code	

Telephone Number:	Area Code	Number	Fax Number:	Area Code	Number

Applicant/Physician Member's Signature

mm dd yyyy

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