

# Clews Benefits Management

## Enrollment Card for Employee Benefits

Is this your first time enrolling on this plan?

**Yes**

**No**

<b>Last Name</b>	<b>First Name</b>	<b>Date of Birth</b>

Please provide your:

<b>Address</b>		
<b>City</b>	<b>Province</b>	<b>Postal Code</b>
<b>Phone Number</b>		<b>Fax Number</b>

Are you choosing: (Please check)

1. Single Coverage     
  2. Family Coverage     
  3. Waive/No Coverage

If applicable, please enter all dependent information. If the dependent is not a resident of the same province as you (the employee), please note their province

Name	Date of Birth (m/d/y)	Relationship (i.e. spouse, child)	Are they attending school full time?

<b>Effective date of enrollment</b>
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\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date