RESET FORM

Hamilton
Human Resources

Benefit Enrolment/Change Form

HRBA-01

This form is to be completed by the employee to enrol in benefits or to change/update dependent information. Save or download the PDF onto your device to complete the form and submit using the "**Submit to Benefits**" button.

Section A:	**Plan Member Information**			
Employee ID	**Department** Select		**Union** Select	
First Name	**Last Name**		**Sex** Select	**Marital Status** Select

Section B:	**Enrolment/Change Information**
Effective Date of Change (D/M/Y)	**Type of Change** Select

Section C: Level of Coverage of Required

☐ **Single** ☐ **Family**

Section D: Dependent Information

Relationship	First Name	Last Name	Sex	Date of Birth	Student	Disabled
Select			Select		Select	Select
Select			Select		Select	Select
Select			Select		Select	Select
Select			Select		Select	Select
Select			Select		Select	Select
Select			Select		Select	Select
Select			Select		Select	Select
Select			Select		Select	Select
Select			Select		Select	Select
Select			Select		Select	Select

Section E: Coordination of Benefits

Is your spouse covered for benefits under another plan?	**Do your children have benefits under a plan other than yours? If yes, provide the name and birth date of the plan holder. If details vary by child, please provide details below.**		
Health Select Dental Select	Health Select Dental Select	**Plan Holder Name**	**Date of Birth (D/M/Y)**

Additional COB Information:

Section F: Spousal Declaration (Only complete this section if you have a spouse)

I declare that my spouse is my legally married spouse or is a person of the opposite or same sex with whom I have continuously cohabitated with, in a common-law relationship for a minimum of 12 consecutive months and is legally represented as my spouse. ***Please note that divorced spouses and spouses of common-law relationships that have ended are not eligible dependents.***

☐ **I agree with the Spousal Declaration**

Plan Member Signature: _____ **Today's Date:** _____

Hamilton
Human Resources

Benefit Enrolment/Change Form

HRBA-01

Section G: Terms, Conditions and Authorization
I certify that the information given on this form is true, correct and complete to the best of my knowledge. I certify that all goods and services that will be claimed will be received by me, my spouse and/or my dependents; and that my spouse and/or dependents are eligible under the terms of my plan. I certify that I will only claim expenses that were incurred by myself or a person(s) for whom I am entitled to claim a medical expense credit under the Income Tax Act (Canada). The submission of fraudulent claims is a criminal offence. The City of Hamilton takes the submission of fraudulent claims seriously. The submission of fraudulent claims will result in the termination of your employment. Suspected fraudulent claims may also be reported to the plan provider and to the appropriate law enforcement agency. I authorize any required payroll deductions for administration of my benefits. I understand and acknowledge that changes received within 30 days of the effective date will be processed as of the effective date. After 30 days, the change will be processed effective as of the date when the form is received by the Benefits department. I understand and acknowledge that I and any dependent(s) will maintain eligibility in the Ontario Health Insurance Plan (OHIP) and that it is my responsibility to notify the benefits department when a dependent no longer qualifies for coverage. I understand and acknowledge that I am responsible for any claim payments incurred by ineligible dependents if I have failed to provide notice that they are no longer eligible for coverage. This form may be executed either in original, faxed or scanned form, or by applying an electronic signature and the parties agree to adopt any signatures received by a facsimile, scan, or electronic means as original signatures of the Plan Member. ☐ **I have read and agree with the Terms, Conditions and Authorization** **Plan Member Signature:** _____ **Today's Date**: _____

Section H: How to Submit		
SUBMIT TO BENEFITS	HR.Benefits@hamilton.ca	Benefits, Human Resources City of Hamilton 71 Main St. W. Hamilton, ON L8P 4Y5

Upon completion click "Submit to Benefits" and the Benefits team will process your request within 2-3 business days. Please allow up to 2 weeks for the information to be updated with Manulife.

The City of Hamilton collects information under the authority of section 227 of the Municipal Act, 2001. Any personal information collected on this form will be used by the City of Hamilton, the plan administrator and/or administrators of benefits programs working with the City of Hamilton to administer benefit coverage and determine eligibility. Questions about the collection of this personal benefits related information can be directed to the Benefits Department, Human Resources, 71 Main St. W., Hamilton, ON L8P 4Y5, HR.Benefits@hamilton.ca, 905-546-2424.