



## EMPLOYEE ENROLLMENT FORM

<b>Name of Employer:</b>			
<b>Employee Surname</b>	<b>Given Name</b>	<b>Initial</b>	<b>Gender</b>
<b>Address</b>			
<b>City</b>	<b>Province</b>	<b>Postal Code</b>	
<b>Phone (Res.)</b>	<b>(Bus.)</b>	<b>(Fax)</b>	
<b>SIN #</b>			
<b>Date of Birth</b>			

## DETAILS OF COVERAGE

<b>Date of Hire</b>			
<b>Effective Date of Coverage</b>			
<b>Annual Coverage Amount</b> \$	<b>Single</b>	<b>Family</b>	<b>Coverage Declined</b>
<b>Are you interested in receiving information on other products (eg. Life insurance, Disability Insurance, Critical Illness, Investments?)</b> <div style="display: flex; justify-content: space-around;"> <span>Yes</span> <span>No</span> </div>			

## DEPENDENT INFORMATION

Name	Date of Birth	Relationship	If F/T Student, name institution.

I hereby authorize DHC Administrators Inc. to use my Social Insurance Number for identification purposes.

Signature \_\_\_\_\_

Date \_\_\_\_\_

### DHC Administrators Inc.

P.O. Box 3190  
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Airdrie, AB T4B 2B5

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Toll Free: 1.877.912.4395

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