



## EMPLOYEE ENROLLMENT FORM

(Please complete form in full)

Company _____
Contact _____
Phone # ( ) _____ E-mail _____
Employer Approval _____ Date _____

Employee Surname	Given Name	Initial	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male
Address			
City	Province	Postal Code	
Phone (Res.)	(Bus.)	(Fax)	
E-mail		SIN#	
Date of Birth (Month)	(Day)	(Year)	

### DEPENDENT INFORMATION

Surname	Given Name	Initial	Gender F/M	Date of Birth Month/Day/Year	Relationship	If F/T Student, name institution (i.e.: College, University)

I hereby certify that I wish to participate in the Employee Health Care Plan and that the information above is correct. I also authorize DHC Administrators Inc. to use my Social Insurance Number for identification purposes.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**DHC Administrators Inc.**

5, 118 Main Street NE  
Airdrie, AB T4B 0R3

Phone: 403.912.4395  
Toll Free: 1.877.912.4395

[www.dhcadmin.com](http://www.dhcadmin.com)