Southwest Nova
INSURANCE GROUP INC.
Empowering People. Protecting Lives.

DCM benefits.com

Group Health & Dental

Toll Free: 1-800-566-5559 ~ Ph: 902-365-5166 ~ Fax: 902-365-5141
service@dcmbenefits.com
260 Main Street, Wolfville, Nova Scotia B4P 1C4

EMPLOYEE APPLICATION / CHANGE FORM

☐ New Enrollment

☐ Change Type of Change: _____

Employer / Plan Selection (to be completed by the plan administrator)

Company Name: _____

Employee Direct Deposit Information: ***Attach copy of VOID cheque for direct deposit banking for claim reimbursement***

Employee / Participant Details (to be completed by the employee

Last Name: _____ First Name: _____ M/ F

Address: _____

City/Town: _____ Postal Code: _____ Phone Home: _____

Email: _____ Date of Birth(mm/dd/yyyy): _____

Marital Status: _____ Coverage Status: Single or Family

Dependent Details (to be completed by the employee)

(mm/dd/yyyy)

Spouse: Last Name: _____ First: _____ M/ F. DOB: _____

Child 1: Last Name: _____ First: _____ M/ F DOB: _____

Child 2: Last Name: _____ First: _____ M / F DOB: _____

Child 3: Last Name: _____ First: _____ M / F DOB: _____

Child 4: Last Name: _____ First: _____ M / F DOB: _____

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Please indicate below if any of your dependents are full time students over age 21

Name of over age student	College/University Attended	Enrolled From	Enrolled To

Please indicate the name of any disabled dependent

_____

Co-ordinator of Benefits / Refusal of Coverage (to be completed by the employee)

If you and/or your dependents are presently insured for Health Care and/or Dental benefits under your spouse's group policy you may co-ordinate benefits or refuse coverage under this contract by completing the appropriate areas.

My spouse has coverage through _____(insurance company), under policy No. _____

I wish to co-ordinate coverage with my spouse's plan
I refuse insurance on myself and dependents under: Health Dental
I refuse insurance on my dependents under: Health Dental

I, _____, am covered under another plan and have been offered the opportunity to participate in my employer's employee benefit program. I understand the benefits offered and I do not wish to enroll in the following benefits (please specify below);

Complete Group Benefit package (or specify the following benefits)
Health and Dental Coverage
Life, AD&D and Long Term Disability Coverage

I understand that by refusing the benefits specified above, my heirs /beneficiaries and I have no claim, now or in the future, for benefits under the program. I hold my employer, its representatives and the insuring company(ies) harmless from all future claims. I also understand that it is my responsibility to notify my employer of any status changes that may affect my benefits. If I wish to participate in the employee benefit program at a later date or do not notify my employer of a status change within 31 days, participation will be subject to the insurer's approval. I may be required to provide evidence of my good health and/or my dependents' good health.

_____ _____ _____
Sign here ONLY if you do not want coverage Witness Date: (mm/dd/yyyy)

Stop Loss (to be completed by the employee)

As part of the Health benefit provided through my employer (myself and my dependents) wish to be insured under the group insurance stop loss protection program.

Note: For consideration under this policy the following questions must be completed

Have you or any of your dependents, on an individual basis, incurred more than $3,750.00 in health expenses in the last twelve (12) month period?

No: Yes: If yes, the approximate amount incurred $ _____

Name of applicable person (dependent) _____ DOB: _____ (mm/dd/yyyy)

I hereby authorize the release of medical claims information solely for the purposes of determining eligibility and validating claims under this policy. I understand that this information can be forwarded to any other third party and will only be used for determining eligibility and validating the claim according to the terms of the Group Insurance Stop Loss Policy.

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Authorization (to be completed by the employee)

By providing this information I am authorizing the applicable insurance carriers, agents and service providers to use and exchange information collected in this form to underwrite, administer and adjudicate claims. I also authorize my plan sponsor to use this same information for benefits administration and to make any necessary payroll deductions, which may be required.

Employee/Participant Signature: _____

Employee/Participant Name (Please Print): _____

Date: _____
(mm/dd/yyyy)

Do you wish to receive electronic communications and updates from SWN in the future? ☐ Yes ☐ No

If No, please call 902-365-5166

Employer / Plan Selection (to be completed by the plan administrator)

Company Name: _____

_____
Name of Administrator

Phone Number Administrator: _____ Email: _____

Employee's Name (if not same as administrator): _____

Annual Allotment: $_____

Prorated Amount: $_____
(divide allotment by 12 times the number of months left in calendar year)

Start Date (mm/dd/yyyy): _____

Other Instructions: _____

_____

_____
Signature: Administrator / Owner

Premium calculation = allotment + administration fee + HST or GST, Provincial Premium Tax if applicable, divided by 12 months, plus Stop Loss and OOC premium.

☐ Your plan is a Health Spending Account, the allotment is the annual or prorated amount assigned to the employee.

Administrator may fax or scan and e-mail enrolment/change form to SWN. The original must be kept on file or mailed.

Group rates for Stop Loss are not available for groups under 5 primary employees. The Stop Loss group rates require 5 employees with claims experience. Groups without Claims experience, regardless of size will have a $15,000 deductible with a $50,000 drug limit in first year. Claims will be assessed following first year, deductible may be lowered, and drug limit increased to $100,000 if claims experience falls within underwriting guidelines.