BENEFITS ENROLMENT FORM

UNIVERSITY OF TORONTO

This form must be completed by eligible employees. Employees must return the completed and signed Benefits Enrolment Form to your Divisional HR Office (DHRO) for processing.

Employee Information

Employee Number		**Employee Status** ☐ Active ☐ On Leave	
First Name	**Middle Initial(s)**	**Last Name**	**Date of Birth** (dd/mm/yyyy)

Reason for Completing

☐ New Hire ☐ Rehire

Life Event Change

☐ Married ☐ Common-law ☐ Divorced ☐ Separated ☐ Widowed ☐ Adding Dependants

Other

☐ Open Enrolment ☐ Name change/correction ☐ Date of birth correction ☐ Other

Effective date of life event or change (dd/mm/yyyy)

Section 1: Group Health Benefits

Please note:
- Exemption: this option is only allowed if you are covered under a Spouse's Insurance for the mandatory benefits (Dental Care & Vision Care)
- Rejection: this only applies for employees with part-time employment
- Check the box Coordination of Benefits (COB) if you are also covered by another plan

	Single	**Family**	**Exempt**	**Reject**	**COB**
Extended Health Care	☐	☐	☐	☐	☐
Dental Care	☐	☐	☐	☐	☐
Vision Care	☐	☐	☐	☐	☐
Semi-Private Hospital	☐	☐	☐	☐	☐

Family Composition

- 'X' includes trans, nonbinary, and two-spirit identities, or can be used for those who don't want to disclose an identity.

Last Name	**First Name**	**Date of Birth** (dd/mm/yyyy)	**Sex** (M/F/X)	**Spouse/Child**	**Add**	**Remove**
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐

Section 2: Long Term Disability Coverage (LTD)

LTD Insurance is mandatory - you will be automatically enrolled.

Section 3a: Basic Life Insurance

Basic Life Insurance is mandatory. You will be automatically enrolled with one times your annual base salary to a maximum of $125,000 (100% employer paid). In the event that you die while covered under the University of Toronto Group Life insurance policy, your death benefit is payable to your designated beneficiary or estate.

Section 3b: Supplemental Life Insurance

This insurance is in addition to Basic Life Insurance.

Supplemental Life Insurance Request Elect one option only	○ I do not wish coverage under The Group Supplemental Life Insurance	○ One times annual base salary	○ Two times annual base salary	○ Three times annual base salary	○ Survivor Income Benefit*	○ Survivor Income Benefit* plus One times base salary

*The **Survivor Income Benefit** is only available to staff members with a Spouse and/or dependant child(ren)

Section 3c: Beneficiary Designation for Basic and Supplemental Life Insurance

This section must be completed to designate one or more person(s) as beneficiaries for your life insurance. If you do not designate a named beneficiary, your estate will be appointed at 100%. If more than one Beneficiary is named, life insurance will be divided equally between Beneficiaries, unless percentage allocated below is different and total 100%. I name the following person(s) as my beneficiary(ies):

Beneficiary Name (first, middle, last)	**Date of Birth** (dd/mm/yyyy)	**Relationship to employee**	**Address**	**Percent (%)**

Section 3d: Trustee Appointment for Minor Beneficiaries (if applicable):

If you designate a minor (an individual under the age of 18) as your Beneficiary, you may also appoint an individual or organization as trustee to receive the benefit in trust for the minor. I hereby appoint the following trustee to receive and hold in trust, on behalf of any beneficiary money payable to the beneficiary under this group benefits plan where, at the time payment is to be made, the beneficiary is a minor or otherwise lacks legal capacity. Any such payment, to its extent, will release the insurance company from further liability. The trust will terminate once the beneficiary is of the age of majority.

Trustee Name	**Phone number**
Address	

Section 4: Authorization and Declarations

This section must be signed and dated. Please read the following information carefully.

I have read and understand and agreed with the contents stated in this form:

- I am applying for the benefits selected on this form and I authorize the University to take the benefit plans premium deductions from my pay.
- I authorize the University of Toronto, the appointed insurance company, its agents and service providers to the collection, use and exchange personal information about me, my Spouse and dependents, when necessary for the purpose of administering the benefit plans in which I may participate. Our insurance carriers recognize and respect the importance of Privacy. To obtain information regarding the Privacy Guidelines of each carrier with respect to personal information policies and practices (including with respect to service providers), please review Group Insurance Carriers Privacy Policies available in the HR Service Centre.
- I am authorized to disclose information about my Spouse and dependents in order to enrol them in the plan.
- I declare that the information provided is true, correct and complete to the best of my knowledge.
- I agree that a photocopy or electronic copy of this authorization is as valid as the original.

Employee Signature		**Date** (dd/mm/yyyy)
Employer Representative Name	**Employer Representative Signature**	**Date Enrolment Form Received by Employer** (dd/mm/yyyy)