



### PHSP PLAN MEMBER ENROLLMENT FORM

#### Company Information

Company Name

#### Plan Member Information

Last Name

First Name

Middle Initials

Mailing Address

City

Province

Postal Code

Email

Office Telephone Number

(  )

Extension

Alternate Number (Mobile or Home)

(  )

Date of Birth (YYYYMMDD)

Date of Hire

Job Classification or Annual Benefit Limit

 or \$ 

#### List of Dependants

Name

Date of Birth (YYYYMMDD)

Relationship to Dependand

Name

Date of Birth (YYYYMMDD)

Relationship to Dependand

Name

Date of Birth (YYYYMMDD)

Relationship to Dependand

Name

Date of Birth (YYYYMMDD)

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Relationship to Dependant

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Relationship to Dependant

Name

Date of Birth (YYYYMMDD)

Relationship to Dependant

## Authorized Signatures

**Employee:** I confirm participation and eligibility to participate in the Navancorp Benefits PHSP

Signature of Employee: \_\_\_\_\_

Date(YYYYMMDD)

**Administrator :** I have the permission of the Employee to share the information and that the Employee was informed and is eligible to participate in the Navancorp Benefits PHSP.

Signature of Administrator: \_\_\_\_\_

Date (YYYYMMDD)

## Following Steps

\*Please return this form, signed and dated, to the following address:

**navancorp**  
PO Box 46  
Navan, ON  
K4B 1J3

\*Scanned files, once completed and signed, can be emailed to [info@navancorp.ca](mailto:info@navancorp.ca)