INTERACTIVE FORM - CLICK ON FIRST LINE TO BEGIN. USERS OF READER 7 AND LATER CAN SAVE DATA TYPED INTO THIS FORM

PRINT BLANK FORM | PRINT COMPLETED FORM | RESET FORM (CLEAR ALL FIELDS)

MediDirect®
Your Health, Dental & Wellness Benefit Plan

EMPLOYEE
Personal Information and Authorization

EMPLOYEE INFORMATION

Name _____
First Name Initial Last Name

Address _____

City or Town _____

Province _____ Postal Code _____

Telephone: Res. _____ Cell. _____

Email Address _____

Employer _____

SIN _____

Date of Birth _____
Month Day Year

Sex ❑ Male ❑ Female

Marital Status ❑ Single ❑ Married ❑ Common Law

DEPENDENT INFORMATION

Dependent means: (a) a person co-habitating with the Employee who is either legally married to the Employee; or living with the Employee, and who is publicly represented as the Employee's spouse; (b) an unmarried Child under 21; (c) an unmarried Child who is registered and attending as a full-time Student at an institute of higher learning, and who is under age 25; (d) an unmarried Child who is incapable of supporting himself because of a mental or physical handicap. Child means, a child of the Employee or his spouse, or common law spouse, and shall include a stepchild, adopted child, or foster child.

Relation	Name of Dependent (First Name, Initial, Last Name)	Sex	Date of Birth (Month, Day, Year)	Full Time Student	Disabled Dependent
Spouse		❑ M ❑ F		N/A	N/A
Child		❑ M ❑ F		❑ Yes ❑ No	❑ Yes ❑ No
Child		❑ M ❑ F		❑ Yes ❑ No	❑ Yes ❑ No
Child		❑ M ❑ F		❑ Yes ❑ No	❑ Yes ❑ No
Child		❑ M ❑ F		❑ Yes ❑ No	❑ Yes ❑ No
Child		❑ M ❑ F		❑ Yes ❑ No	❑ Yes ❑ No
Child		❑ M ❑ F		❑ Yes ❑ No	❑ Yes ❑ No

EMPLOYEE AUTHORIZATION

I have read and understood the contents of this form. I certify that the information in this form is true and complete, to the best of my knowledge. If applying for benefits for my dependents, I am authorized to release information concerning my spouse and my dependents for the purposes of determining their eligibility for benefits. I authorize payroll deductions by my employer if required and consent to the use by MediDirect® Inc. of my Social Insurance Number for the purpose of benefits administration. I give consent on the understanding that all information provided by me will be used solely for purposes of administration and management of my benefit plan, as well as enable MediDirect® Inc. to keep me better informed of all benefits that are or may become available.

Signature _____ Date _____ PRINT COMPLETED FORM

PRIVACY STATEMENT

At MediDirect® Inc., the privacy of clients, employees and their records is our priority. Confidential information is maintained in files regarding your contract with us, as well as personal and medical information. Our files are kept for the purpose of providing you with health and dental benefit plan coverage and other products or services that will help you meet your health and wellness objectives. This personal information will not be provided to any third party, without prior written consent. Access to personal information is restricted to only those employees of MediDirect® Inc. who are responsible for administration, the Privacy Officer of MediDirect® Inc., or any other person(s) whom you authorize.

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