ENROLLMENT CARD FOR PACIFIC FIRST

CLASS:_____

NAME Last First Initial	MALE ☐ SINGLE ☐ FEMALE ☐ MARRIED ☐	GROUP NO. P9525
ADDRESS	DATE OF BIRTH Day Month Year	EFFECTIVE DATE
CITY PROV POSTAL CODE	Social Insurance Number – –	TELEPHONE NO.

EMPLOYER OR GROUP	DEDUCTIBLE	BASIC	MAJOR	ORTHO
	$ _____	_____ % $ _____	_____ % $ _____	_____ % $ _____

List Dependents Below (spouse first)		Sex M/F	Date of Birth Day	Month	Year
01					
02					
03					
04					
05					
06					

Beneficiary (if applicable) AD&D

Print name / relationship to employee

Extended Health Benefits
To be included in dental limit

_____ % YES ☐

$ _____ NO ☐

Family limit ☐

Individual limit ☐

Shaded Area for Office Use Only

I HEREBY APPLY FOR THE GROUP DENTAL/EHB COVERAGE FOR WHICH I MAY BE ELIGIBLE, AND I AUTHORIZE THE RELEASE OF MY DENTAL/MEDICAL RECORDS TO PACIFIC FIRST. SEE REVERSE.

EMPLOYEE'S SIGNATURE _____

APPLICATION DATE _____