NEW EMPLOYEE ENROLLMENT FORM

Employer (Company) name: ____

Employee Name | Employee Classification | Date of Birth | Gender

______________________ ____________________ ___________ _____

Home Address

____

Employee Phone # Email

_____________________________ _________________________________

Name of Dependent | Relationship | Date of Birth

______________________ _______________________ ____________________

Name of Dependent | Relationship | Date of Birth

______________________ _______________________ ____________________

Name of Dependent | Relationship | Date of Birth

______________________ _______________________ ____________________

A Dependent means: a) Your spouse, legal or common-law
b) Your unmarried children under the age of 21
c) Your children under age 25 if they are full time students.
d) Your children who are incapable of supporting themselves because of physical or mental disorder are covered without age limit if the disorder began prior to age 21, or while they are students prior to age 25.

I wish to enroll in **Diversified Insurance Services Ltd.** Private Health Services Plan and confirm the information I have supplied above is accurate.

Employee Signature: _________________________ Dated this ____ day of _______, 2024.

I wish to enroll the above noted Eligible Employee in **Diversified Insurance Services Ltd.** Private Health Services Plan.

Employer Signature: _________________________ Dated this ____ day of _______, 2024.

My Benefits Plus+
Private Health Services Plan