Bene-D-Duct
A Division of Direct Dimensions Actuarial Services Inc.
6013 Yonge Street, Suite 320
Toronto, Ontario M2M 3W2

EMPLOYER FORM

PLEASE PRINT CLEARLY

Name of business	Business ID # (if known)	TYPE OF BUSINESS
Address of business (including postal code)		☐ Corporation ☐ Sole Proprietorship ☐ Partnership
Contact person	Title	☐ Mr. ☐ Miss ☐ Dr. ☐ Mrs. ☐ Ms.

Telephone number	Fax number	E-mail address

Business's fiscal period for income tax	Requested effective date

Describe your business.

How many employees will initially be covered under this plan?

BENEFIT PLAN SELECTIONS

	Full Coverage	Annual Deductible	Reimbursement Percentage	Annual Maximum
Dental				
☐ All dental	☐			
☐ Preventative, diagnostic, and minor restorative	☐			
☐ Endodontics and periodontics	☐			
☐ Major restorative	☐			
☐ Orthodontics	☐			
☐	☐			
Medical				
☐ All medical	☐			
☐ Prescription drugs	☐			
☐ Semi-private hospital accommodations	☐			
☐ Private hospital accommodations	☐			
☐ Vision benefits	☐			
☐ All other eligible health benefits	☐			
☐	☐			

Coverage
- ☐ Canada only
- ☐ Worldwide
- ☐ Canada only plus travel medical insurance premiums

Overall Annual Maximum
- ☐ Single
- ☐ Couple
- ☐ Family

TO BENE-D-DUCT: PLEASE PREPARE A BENEFIT PLAN TEXT FOR OUR IMPLEMENTATION AND ISSUE TO US YOUR CONTRACT TO ADMINISTER THE PLAN. I CERTIFY THAT ALL INFORMATION ON THIS FORM IS COMPLETE AND ACCURATE.

Authorized Signature for Business	*Name*	*Title*	*Date*

Bene-D-Duct
A Division of Direct Dimensions Actuarial Services Inc.
6013 Yonge Street, Suite 320
Toronto, Ontario M2M 3W2

EMPLOYEE FORM

PLEASE PRINT CLEARLY

Name of business	Business ID # (if known)	Day-time telephone number
Name of employee	Employee ID # (if known)	☐ Mr. ☐ Miss ☐ Dr. ☐ Mrs. ☐ Ms.
Business address (including postal code)		E-mail address
Home address, if required (including postal code)		Benefit cheques to be sent to ☐ Business address ☐ Home address

ACTION REQUESTED

☐ Add employee and family members to plan
☐ Delete employee and family members from plan
☐ Add spouse and/or child
☐ Delete spouse and/or child.

Requested effective date

IMMEDIATE FAMILY MEMBERS ENROLLMENT INFORMATION

Immediate family members	Given name	Surname (if different from employee's surname)	Sex	Date of birth day/mo/yr
Employee			☐ Male ☐ Female	
Spouse			☐ Male ☐ Female	
1st child*			☐ Male ☐ Female	
2nd child*			☐ Male ☐ Female	
3rd child*			☐ Male ☐ Female	
4th child*			☐ Male ☐ Female	
5th child*			☐ Male ☐ Female	
6th child*			☐ Male ☐ Female	

* A child is eligible only if financially dependent upon the Employee and/or Spouse.

I CERTIFY THAT ALL INFORMATION ON THIS FORM IS COMPLETE AND ACCURATE.

_________________________ Signature of Employee

__________ Date