NBTF GROUP INSURANCE TRUSTEES

FIDUCIAIRES DE L'ASSURANCE COLLECTIVE DE LA FENB

NBTF Long-Term Disability Open Enrolment

Personal Information

Employee Full Name **Date of Birth** (d/m/y)

Employee Number

Home Address

☐ **I wish to be insured under the Long-Term Disability coverage.**

If you have any questions regarding your coverage under the NBTF Group Insurance Plan, please do not hesitate to contact Johnson Inc. at 506-458-1981 (local) or 1-888-851-5500 (toll-free) or via email pbadminnb@johnson.ca.

Authorization

I understand that if I am not actively at work on the effective date, coverage will take effect on the date that I return to active, full-time employment.

I hereby apply for benefits under the NBTF Group Insurance Program and authorize any required payroll/bank deductions. In order to determine my eligibility for benefits and administer group benefit coverage(s), I give Johnson Inc. (and any relevant carrier as may be applicable) consent to: Collect and communicate personal information about me from people or organizations including any health care practitioner, medical facility or provider of health care/dental services, and provincial health insurance plan, insurance company or reinsurer, my plan sponsor or former plan sponsor, government agency, or financial institution(s). I acknowledge that more detailed information concerning how and why Johnson Inc. collects, uses and discloses my personal information is available at www.johnson.ca.

If I have declined coverage, I understand that I may not be able to obtain coverage at a later date if I change my mind. My ability to obtain coverage is subject to the specific requirements and rules of the applicable insurance program. I am so responsible for the decisions to decline or accept coverage reflected in this enrollment form. I understand that I may not claim for any loss or damage arising directly or indirectly from the elections made in this form or from participation in the Plan against the NBTF Group Insurance program, the NBTF Group Insurance Trustees or their successors or any service provider, employee or agent of the Plan or the Trustees. In signing this form, I specifically release those parties from any such liability. The information given on this form is true, correct and complete to the best of my knowledge.

Employee's Signature:_____ **Date:** (d/m/y) _____

JOHNSON