



NEWBORN/ADOPTION ENROLMENT FORM FOR GROUP EXTENDED HEALTH AND DENTAL COVERAGES

Personal information provided on this form is collected pursuant to section 26 of the *Freedom of Information and Protection of Privacy Act*, RSBC 1996, c. 165 (FIPPA) for the purpose of benefits administration, claims submission and to make any necessary payroll deductions. The information will be used, retained & disclosed by UBC in accordance with FIPPA. For further information, please email benefitsinfo@hr.ubc.ca.

Name of Employee (first name, last name)	Employee Identification Number
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NEWBORN/ADOPTEE INFORMATION

Name of Newborn/Adoptee (first name, last name)	Baby's Sex	Date of Birth (month, day, year)
	Personal Health Coverage Number	Date of Adoption, if applicable (month, day, year)

Please enroll my newborn/adopted child in the following (check all that apply):

- Extended Health Benefits
- Dental Benefits
- Employee Family and Assistance Program (EFAP)

AUTHORIZATION:

I agree to the conditions of the contract between my employer (UBC) and benefits providers of the above plans.

I understand that my dependent(s) and I must be continuously enrolled under a Canadian Federal or Provincial Health Plan in order to participate in the extended health care plan.

I authorize UBC to disclose information about my dependent (s) in order to enroll them in the above plans. By enrolling in the above plans, I authorize the following:

- The University of British Columbia to use the information collected on this form for benefits administration and to make any necessary payroll deductions,
- The providers of UBC's benefits plans, its agents and service providers to use and exchange information collected in this form to underwrite, administer benefits and pay claims.

I agree that all information in this form is true and complete. A photocopy or an electronic version of this authorization is as valid as the original.

Signature	Date Signed (month, day, year)
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