Hennick Bridgepoint Hospital
Sinai Health

Onboarding Checklist

Welcome to Hennick Bridgepoint Hospital! We are happy you have decided to join the Bridgepoint Team to help change the world for people living with complex chronic disease. To guide you through the onboarding process and prepare you for your first day, we have provided you with a series of forms that you will need to complete prior to your start date. This Onboarding Checklist will assist you with completing your forms and serve as a guide for the material.

After you have completed your forms and this checklist please bring all documents to the Human Resources Department **during your first week** for processing.

Document	Description and Instructions	Completed (please check box)
Employment Status and Benefit Option Form	• Please note Human Resources will complete all effective dates on your behalf where applicable. • Please complete and sign the form	☐
Direct Deposit Form	• Attach a void cheque or bank certified direct deposit banking information directly to the form and sign. • Please complete the bank address information, bank code, transit number and account number.  • Pay days are every other Thursday by direct deposit. The payroll schedule is available on the Bridgepoint Portal.	☐
Federal Tax Form – Personal Tax Credits Return – TD1	• Complete the personal information, applicable tax amounts and final total in section 13 and sign the reverse side of the form	☐
Provincial Tax Form – Ontario Personal Tax Credits Return	• Complete the personal information and applicable tax amounts and final total in section 10 and sign the reverse side of the form.	☐
Long Term Disability Option Form (Non Union Only)	Please select your premium payment option and sign the form.	☐
Healthcare of Ontario Pension Plan (HOOPP) Information:	Full time permanent employees will be enrolled immediately by Human Resources in HOOPP effective the first day of full time employment. HOOPP will send a 'Welcome Kit' to your home address. Pension deductions occur every pay. *Please check the appropriate box below if any of the following apply regarding your current pension status:*	☐
Manulife Form – Enrollment	• Complete sections 2, 4, 5 (if applicable) • Do not complete section 3 • Sign and date	☐
Manulife Form – Life Insurance Beneficiary	• Complete sections 2, 3, 4, and if applicable 5, 6, 7. • Do NOT complete section 8 • Sign and date	☐
Mandatory Training	Bridgepoint Health is committed to ensuring that employees are provided with training in accordance with our organization's policies and applicable legislation. Completion of this training is a requirement and condition of continued employment with Bridgepoint Hospital. **Documents to follow include:** ☐ Confidentiality Agreement* ☐ Code of Ethics* ☐ Workplace Violence Policy AH 445 (return signature page only)* ☐ Workplace Harassment and Abuse Policy AH 440 (return signature page only)*	☐

Document	Description and Instructions	Completed (please check box)
	☐ Accessible Customer Service Independent Study Accessible Customer Service Quiz* ☐ Bill 168 Independent Study Bill 168 Quiz* ☐ WHMIS Training Independent Study WHMIS Quiz* Please return the signed policies and completed quizzes **(marked with an asterisk*)** to Human Resources when you submit your completed documentation.	
Additional Documentation	Photocopies of the following documents are required to be submitted with your documentation package: ☐ Proof of Age (one of the following): birth certificate, driver's license, passport, or citizenship card. ☐ Social Insurance Number (SIN) Card or other government documentation with SIN number. SINs that begin with a "9" must be accompanied with a valid work permit. ☐ Copy of required educational qualifications for the position ☐ Proof of current registration with applicable college as required by your classification. ☐ Copy of current Basic Cardiac Life Support (BCLS) (where applicable). ☐ Letters for credit for past experience (where applicable). ☐ A signed copy of your offer letter. ☐ The Onboarding Checklist with signature	☐

Address Disclosure to the Union (Applicable to CUPE members only)
Membership lists are provided to the Union on a quarterly basis. You have the option to exclude your contact information from this list. Please note, no reply is considered consent to share the information with the Union.

☐ Object

Notice of Collection:
The personal information you give us on the applicable forms allows us to process your payroll and benefits in relation to your employment contract. We collect this information under the authority of the Public Hospitals Act, Employment Standards and the Income Tax Act. Should you have any questions, please contact the Freedom of Information office at 416-461-8252, ext. 2420

Identification Badges and Parking Requests:
All employees are required to wear Hospital issued photo identification badges. Human Resources has sent a badge request to the Security Department on your behalf. Please visit a Security Officer, Room G.040 in order to have your ID badge processed. Requests for parking access may also be addressed through the Security Office.

If you need assistance completing the documents enclosed, or have any questions please contact Human Resources at (416) 461-8252, ext. 2007 to schedule an appointment.

Thank you,

The Human Resources Team

☐ **I HAVE COMPLETED THE DOCUMENTATION PROCESS AND WILL SUBMIT ALL REQUIRED DOCUMENTS AND THE ONBOARDING CHECKLIST TO HUMAN RESOURCES IN THE ENVELOPE PROVIDED.**

_____ SIGNATURE

_____ DATE

Hennick Bridgepoint Hospital
Sinai Health

Employee # _____

FULL TIME
EMPLOYMENT STATUS AND BENEFIT OPTION FORM

A. PERSONAL INFORMATION

☐MALE ☐FEMALE _____
LAST NAME GIVEN NAME

_____
APARTMENT/UNIT# ADDRESS CITY/TOWN PROVINCE POSTAL CODE

_____
PRIMARY TELEPHONE # ALTERNATE TELEPHONE # EMAIL ADDRESS

_____ _____
DATE OF BIRTH (dd/mm/yyyy) SOCIAL INSURANCE #

_____
EMERGENCY CONTACT: NAME RELATIONSHIP

_____
PRIMARY TELEPHONE # ALTERNATE TELEPHONE #

B. HEALTHCARE OF ONTARIO PENSION PLAN (HOOPP)

EFFECTIVE DATE: _____

☐ ENROLLMENT ON THE FIRST DAY OF EMPLOYMENT

☐ NOT APPLICABLE – FULL-TIME EMPLOYMENT ELSEWHERE (Waiver signed)

C. EMPLOYMENT STATUS: FOR HUMAN RESOURCES USE ONLY

☐ NEW HIRE ☐ TRANSFER

☐ FULL TIME ☐ FULL TIME TEMP ☐ CONTRACT END DATE: _____

_____ EFFECTIVE DATE	_____ CLASSIFICATION	_____ DEPARTMENT/COST CENTRE
_____ HOURLY RATE OF PAY	_____ PROBATION PERIOD/UNION	_____ VACATION WEEKS
_____ HOURS PER WEEK	_____ SENIORITY DATE	_____ SERVICE/VACATION/SALARY DATE

D. PAYROLL #: _____ PLEASE NOTE THAT ALL PAY IS DIRECTLY DEPOSITED

INCOME TAX DEDUCTION: FEDERAL TD1:$ _____ PROVINCIAL TD1 $ _____
PAYROLL AUTHORIZATION FORM: ☐ ATTACHED WITH VOID CHEQUE ☐BANK CERTIFIED

E. CURRENT COVERAGE ELECTIONS:

EXTENDED HEALTH/HOSPITAL (1ST of the month after the 1 month waiting period)	☐ WAIVE	☐SINGLE	☐FAMILY	EFFECTIVE: _____
DENTAL (1ST of the month after the 6 month waiting period)	☐ WAIVE	☐SINGLE	☐FAMILY	EFFECTIVE: _____
GROUP LIFE (1ST of the month after the 3 month waiting period)	☐ 2X ANNUAL EARNINGS (AE)			EFFECTIVE: _____
LONG TERM DISABILITY: (1ST of the month after the 6 month waiting period)				EFFECTIVE: _____

LONG TERM DISABILITY OPTION FOR NON UNION ONLY: ☐ TAXABLE (25%) ☐ NON TAXABLE (100%)

I certify that the foregoing statements are correct and agree to and understand the conditions of my employment. I also authorize the use of my social insurance number for benefit purposes

_____ _____
DATE **SIGNATURE OF EMPLOYEE**

Hennick Bridgepoint Hospital
Sinai Health

Non-Union
Long Term Disability Option Form

Name (*Please PRINT*): _____

Position: _____

Department: _____

(Please check one)

☐ I elect to continue to pay 100% of the premiums for Long Term Disability benefits. I understand that I will receive a tax free benefit upon an approved application for LTD coverage from our insurance company, which is in keeping with the Income Tax Act requirement.

or

☐ I elect to contribute 25% of the premiums for Long Term Disability benefits. I understand that any LTD payments will be taxed upon an approved application for LTD coverage from our insurance company, which is in keeping with the Income Tax Act requirement.

I understand that my decision is final and binding.

Signed: _____

Dated: _____

Canada Revenue Agency | Agence du revenu du Canada

2024 Personal Tax Credits Return

Protected B when completed

TD1

Read page 2 before filling out this form. Your employer or payer will use this form to determine the amount of your tax deductions.

Fill out this form based on the best estimate of your circumstances.

If you do not fill out this form, your tax deductions will only include the basic personal amount, estimated by your employer or payer based on the income they pay you.

Last name	First name and initial(s)	Date of birth (YYYY/MM/DD)	Employee number

Address	Postal code	**For non-residents only** Country of permanent residence	Social insurance number

1. Basic personal amount – Every resident of Canada can enter a basic personal amount of $15,705. However, if your net income from all sources will be greater than $173,205 and you enter $15,705, you may have an amount owing on your income tax and benefit return at the end of the tax year. If your income from all sources will be greater than $173,205 you have the option to calculate a partial claim. To do so, fill in the appropriate section of Form TD1-WS, Worksheet for the 2024 Personal Tax Credits Return, and enter the calculated amount here. **15,705**

2. Canada caregiver amount for infirm children under age 18 – Only one parent may claim $2,616 for each infirm child born in 2007 or later who lives with both parents throughout the year. If the child does not live with both parents throughout the year, the parent who has the right to claim the "Amount for an eligible dependant" on line 8 may also claim the Canada caregiver amount for the child.

3. Age amount – If you will be 65 or older on December 31, 2024, and your net income for the year from **all** sources will be $44,325 or less, enter $8,790. You may enter a partial amount if your net income for the year will be between $44,325 and $102,925. To calculate a partial amount, fill out the line 3 section of Form TD1-WS.

4. Pension income amount – If you will receive regular pension payments from a pension plan or fund (not including Canada Pension Plan, Quebec Pension Plan, old age security, or guaranteed income supplement payments), enter **whichever is less**: $2,000 or your estimated annual pension income.

5. Tuition (full-time and part-time) – Fill in this section if you are a student at a university or college, or an educational institution certified by Employment and Social Development Canada, and you will pay more than $100 per institution in tuition fees. Enter the total tuition fees that you will pay if you are a full-time or part-time student.

6. Disability amount – If you will claim the disability amount on your income tax and benefit return by using Form T2201, Disability Tax Credit Certificate, enter $9,872.

7. Spouse or common-law partner amount – Enter the difference between the amount on line 1 (line 1 plus $2,616 if your spouse or common-law partner is **infirm**) and your spouse's or common-law partner's estimated net income for the year if **two** of the following conditions apply:

- You are supporting your spouse or common-law partner who lives with you
- Your spouse or common-law partner's net income for the year will be less than the amount on line 1 (line 1 plus $2,616 if your spouse or common-law partner is **infirm**)

In all cases, go to line 9 if your spouse or common-law partner is **infirm** and has a net income for the year of $28,041 or less.

8. Amount for an eligible dependant – Enter the difference between the amount on line 1 (line 1 plus $2,616 if your eligible dependant is **infirm)** and your eligible dependant's estimated net income for the year if **all** of the following conditions apply:

- You do **not** have a spouse or common-law partner, or you **have** a spouse or common-law partner who does not live with you and who you are not supporting or being supported by
- You are supporting the dependant who is related to you and lives with you
- The dependant's net income for the year will be less than the amount on line 1 (line 1 plus $2,616 if your dependant is **infirm** and you **cannot** claim the **Canada caregiver amount for infirm children under 18 years of age** for this dependant**)**

In all cases, go to line 9 if your dependant is **18 years or older, infirm,** and has a net income for the year of $28,041 or less.

9. Canada caregiver amount for eligible dependant or spouse or common-law partner – Fill out this section if, at any time in the year, you support an **infirm** eligible dependant (aged 18 or older) **or** an **infirm** spouse or common-law partner whose net income for the year will be $28,041 or less. To calculate the amount you may enter here, fill out the line 9 section of Form TD1-WS.

10. Canada caregiver amount for dependant(s) age 18 or older – If, at any time in the year, you support an **infirm** dependant age 18 or older (**other than** the spouse or common-law partner or eligible dependant you claimed an amount for on line 9 or could have claimed an amount for if their net income were under $15,705) whose net income for the year will be $19,666 or less, enter $8,375. You may enter a partial amount if their net income for the year will be between $19,666 and $28,041. To calculate a partial amount, fill out the line 10 section of Form TD1-WS. This worksheet may also be used to calculate your part of the amount if you are sharing it with another caregiver who supports the same dependant. You may claim this amount for more than one infirm dependant age 18 or older.

11. Amounts transferred from your spouse or common-law partner – If your spouse or common-law partner will not use all of their age amount, pension income amount, tuition amount, or disability amount on their income tax and benefit return, enter the unused amount.

12. Amounts transferred from a dependant – If your dependant will not use all of their disability amount on their income tax and benefit return, enter the unused amount. If your or your spouse's or common-law partner's dependent child or grandchild will not use all of their tuition amount on their income tax and benefit return, enter the unused amount.

13. TOTAL CLAIM AMOUNT – Add lines 1 to 12.
Your employer or payer will use this amount to determine the amount of your tax deductions.

Canada

Filling out Form TD1

Fill out this form **only** if any of the following apply:

- you have a new employer or payer, and you will receive salary, wages, commissions, pensions, employment insurance benefits, or any other remuneration
- you want to change the amounts you previously claimed (for example, the number of your eligible dependants has changed)
- you want to claim the deduction for living in a prescribed zone
- you want to increase the amount of tax deducted at source

Sign and date it, and give it to your employer or payer.

More than one employer or payer at the same time

☐ If you have more than one employer or payer at the same time and you have already claimed personal tax credit amounts on another Form TD1 for 2024, you **cannot** claim them again. If your total income from all sources will be more than the personal tax credits you claimed on another Form TD1, check this box, enter "0" on Line 13 and do not fill in Lines 2 to 12.

Total income is less than the total claim amount

☐ Tick this box if your total income for the year from **all** employers and payers will be **less** than your total claim amount on line 13. Your employer or payer will not deduct tax from your earnings.

For non-resident only (Tick the box that applies to you.)

As a non-resident, will 90% or more of your world income be included in determining your taxable income earned in Canada in 2024?

☐ Yes (Fill out the previous page.)

☐ No (Enter "0" on line 13, and do not fill in lines 2 to 12 as you are not entitled to the personal tax credits.)

Call the international tax and non-resident enquiries line at **1-800-959-8281** if you are unsure of your residency status.

Provincial or territorial personal tax credits return

You also have to fill out a provincial or territorial TD1 form if your claim amount on line 13 is more than $15,000. Use the Form TD1 for your province or territory of **employment** if you are an employee. Use the Form TD1 for your province or territory of **residence** if you are a pensioner. Your employer or payer will use both this federal form and your most recent provincial or territorial Form TD1 to determine the amount of your tax deductions.

Your employer or payer will deduct provincial or territorial taxes after allowing the provincial or territorial basic personal amount if you are claiming the basic personal amount **only**.

Note: You may be able to claim the child amount on Form TD1SK, 2024 Saskatchewan Personal Tax Credits Return if you are a Saskatchewan resident supporting children under 18 at any time during 2024. Therefore, you may want to fill out Form TD1SK even if you are **only** claiming the basic personal amount on this form.

Deduction for living in a prescribed zone

You may claim **any** of the following amounts if you live in the Northwest Territories, Nunavut, Yukon, or another prescribed **northern** zone for more than six months in a row beginning or ending in 2024:

- $11.00 for each day that you live in the prescribed northern zone
- $22.00 for each day that you live in the prescribed northern zone if, during that time, you live in a dwelling that you maintain, and you are the only person living in that dwelling who is claiming this deduction

$ _____

Employees living in a prescribed **intermediate** zone may claim 50% of the total of the above amounts.
For more information, go to **canada.ca/taxes-northern-residents**.

Additional tax to be deducted

You may want to have more tax deducted from each payment if you receive other income such as non-employment income from CPP or QPP benefits, or old age security pension. You may have less tax to pay when you file your income tax and benefit return by doing this. Enter the additional tax amount you want deducted from each payment to choose this option. You may fill out a new Form TD1 to change this deduction later.

$ _____

Reduction in tax deductions

You may ask to have less tax deducted at source if you are eligible for deductions or non-refundable tax credits that are not listed on this form (for example, periodic contributions to a registered retirement savings plan (RRSP), child care or employment expenses, charitable donations, and tuition and education amounts carried forward from the previous year). To make this request, fill out Form T1213, Request to Reduce Tax Deductions at Source, to get a letter of authority from your tax services office. Give the letter of authority to your employer or payer. You do not need a letter of authority if your employer deducts RRSP contributions from your salary.

Forms and publications

To get our forms and publications, go to **canada.ca/cra-forms-publications** or call **1-800-959-5525**.

Personal information (including the SIN) is collected and used to administer or enforce the Income Tax Act and related programs and activities including administering tax, benefits, audit, compliance, and collection. The information collected may be disclosed to other federal, provincial, territorial, aboriginal or foreign government institutions to the extent authorized by law. Failure to provide this information may result in paying interest or penalties, or in other actions. Under the Privacy Act, individuals have a right of protection, access to and correction of their personal information, or to file a complaint with the Privacy Commissioner of Canada regarding the handling of their personal information. Refer to Personal Information Bank CRA PPU 120 on Information about Programs and Information Holdings at **canada.ca/cra-information-about-programs**.

Certification

I certify that the information given on this form is correct and complete.

Signature _____ Date _____

It is a serious offence to make a false return.

Ontario

2024 Ontario Personal Tax Credits Return

Protected B when completed
TD1ON

Read page 2 before filling out this form. Your employer or payer will use this form to determine the amount of your provincial tax deductions.

Fill out this form based on the best estimate of your circumstances.

Last name	First name and initial(s)	Date of birth (YYYY/MM/DD)	Employee number

Address	Postal code	**For non-residents only** Country of permanent residence	Social insurance number

1. Basic personal amount – Every person employed in Ontario and every pensioner residing in Ontario can claim this amount. If you will have more than one employer or payer at the same time in 2024, see "More than one employer or payer at the same time" on page 2. **12,399**

2. Age amount – If you will be 65 or older on December 31, 2024, and your net income will be $45,068 or less, enter $6,054. You may enter a partial amount if your net income for the year will be between $45,068 and $85,428. To calculate a partial amount, fill out the line 2 section of Form TD1ON-WS, Worksheet for the 2024 Ontario Personal Tax Credits Return.

3. Pension income amount – If you will receive regular pension payments from a pension plan or fund (not including Canada Pension Plan, Quebec Pension Plan, Old Age Security, or Guaranteed Income Supplement payments), enter **whichever is less**: $1,714 or your estimated annual pension.

4. Disability amount – If you will claim the disability amount on your income tax and benefit return by using Form T2201, Disability Tax Credit Certificate, enter $10,017**.**

5. Spouse or common-law partner amount – Enter $10,528 if you are supporting your spouse or common-law partner and **both** of the following conditions apply:

- Your spouse or common-law partner lives with you
- Your spouse or common-law partner's net income for the year will be $1,053 or less

You may enter a partial amount if your spouse's or common-law partner's net income for the year will be between $1,053 and $11,581. To calculate a partial amount, fill out the line 5 section of Form TD1ON-WS.

6. Amount for an eligible dependant – Enter $10,528 if you are supporting an eligible dependant and **all** of the following conditions apply:

- You do **not** have a spouse or common-law partner, or you **have** a spouse or common-law partner who does not live with you and who you are not supporting or being supported by
- The dependant is related to you and lives with you
- The dependant's net income for the year will be $1,053 or less

You may enter a partial amount if the eligible dependant's net income for the year will be between $1,053 and $11,581. To calculate a partial amount, fill out the line 6 section of Form TD1ON-WS.

7. Ontario caregiver amount – You may claim this amount if you are supporting an eligible infirm dependant aged 18 or older:

- your child or your grandchild (or your spouse or common-law partner);
- your parent, grandparent, brother, sister, aunt, uncle, niece or nephew who is resident in Canada (or your spouse or common-law partner)

To calculate this amount, fill out the line 7 section of Form TD1ON-WS.

8. Amounts transferred from your spouse or common-law partner – If your spouse or common-law partner will not use all of their age amount, pension income amount, or disability amount on their income tax and benefit return, enter the unused amount.

9. Amounts transferred from a dependant – If your dependant will not use all of their disability amount on their income tax and benefit return, enter the unused amount.

10. TOTAL CLAIM AMOUNT – Add lines 1 to 9.
Your employer or payer will use this amount to determine the amount of your provincial tax deductions.

Canada

Filling out Form TD1ON

Fill out this form only if you are an employee working in Ontario or a pensioner residing in Ontario and **any** of the following apply:

- you have a new employer or payer, and you will receive salary, wages, commissions, pensions, employment insurance benefits, or any other remuneration
- you want to change the amounts you previously claimed (for example, the number of your eligible dependants has changed)
- you want to increase the amount of tax deducted at source

Sign and date it, and give it to your employer or payer.

If you do not fill out Form TD1ON, your employer or payer will deduct taxes after allowing the basic personal amount **only**.

More than one employer or payer at the same time

☐ If you have more than one employer or payer at the same time and you have already claimed personal tax credit amounts on another Form TD1ON for 2024, you **cannot** claim them again. If your total income from all sources will be more than the personal tax credits you claimed on another Form TD1ON, check this box, enter "0" on line 10 and do not fill in lines 2 to 9.

Total income is less than the total claim amount

☐ Tick this box if your total income for the year from **all** employers and payers will be **less** than your total claim amount on line 10. Your employer or payer will not deduct tax from your earnings.

Additional tax to be deducted

If you want to have more tax deducted at source, fill out section "Additional tax to be deducted" on the federal Form TD.

Reduction in tax deductions

You may ask to have less tax deducted at source if you are eligible for deductions or non-refundable tax credits that are not listed on this form (for example, periodic contributions to a registered retirement savings plan (RRSP), child care or employment expenses, charitable donations, and tuition and education amounts carried forward from the previous year). To make this request, fill out Form T1213, Request to Reduce Tax Deductions at Source, to get a letter of authority from your tax services office. Give the letter of authority to your employer or payer. You do not need a letter of authority if your employer deducts RRSP contributions from your salary.

Forms and publications

To get our forms and publications, go to **canada.ca/cra-forms-publications** or call **1-800-959-5525**.

Personal information (including the SIN) is collected and used to administer or enforce the Income Tax Act and related programs and activities including administering tax, benefits, audit, compliance, and collection. The information collected may be disclosed to other federal, provincial, territorial, aboriginal or foreign government institutions to the extent authorized by law. Failure to provide this information may result in paying interest or penalties, or in other actions. Under the Privacy Act, individuals have a right of protection, access to and correction of their personal information, or to file a complaint with the Privacy Commissioner of Canada regarding the handling of their personal information. Refer to Personal Information Bank CRA PPU 120 on Information about Programs and Information Holdings at **canada.ca/cra-information-about-programs**.

Certification

I certify that the information given on this form is correct and complete.

Signature _____ Date _____

It is a serious offence to make a false return.

Manulife

Group Benefits
Enrolment or Re-enrolment Application
Bridgepoint Hospital

Section 1 is to be completed by the plan administrator. The remaining sections and Beneficiary Designation form are to be completed by the plan member. Please print clearly in dark ink using CAPITAL LETTERS.

1 Plan sponsor statement

To be completed by Human Resources

Plan sponsor name **Sinai Health System** Plan contract number **01487**

Account/Location number _____ Billing division _____ Plan member's certificate number _____

Permanent hire date (dd/mmm/yyyy) _____ Do you want to waive the waiting period? ◯ Yes ◯ No

Re-hire date (dd/mmm/yyyy) _____ If a re-hire, date previous employment ended (dd/mmm/yyyy) _____

Class/Plan _____ Occupation _____ Hours worked/week _____ Salary $_____ Frequency _____

I certify that the **plan member** listed below is **actively at work** at their usual place of employment in Canada. **Actively at work** means the **plan member** works a normal work schedule of at least the set minimum hours per week as stated in the plan contract over a 52 week period including paid vacation.

Plan administrator signature _____ Date (dd/mmm/yyyy) _____

Registered under the Canadian *Indian Act* for provincial tax exemption purposes? ◯ Yes ◯ No

Is evidence of insurability required? ◯ Yes ◯ No (in order to determine if evidence of insurability is required, please refer to your contract.)

If *yes*, please complete form GL0004E and send to Manulife for processing.

2 Plan member information

To be completed by employee

Plan member's last name _____ First name _____

Date of birth (dd/mmm/yyyy) _____ Gender ◯ Male ◯ Female Province of residence _____

Language ◯ English ◯ French Do you have a spouse? (married, common law or civil union?) ◯ Yes ◯ No

3 Plan member address

Address (number, street, apt.) _____

City _____ Province _____ Postal code _____

4 Application for coverage

Some plans allow refusal of certain benefits if the plan member has coverage under their spouse's plan. If you wish to add coverage at a later date, you may reapply for these benefits at which time satisfactory medical evidence may be required.

Coverage		Options
◯ Single	➔	◯ Health and Dental
◯ Family		◯ Health Only (coverage elsewhere)
		◯ Dental Only (coverage elsewhere)

5 Refusal of benefits

You may refuse Extended Health Care and or Dental Care for yourself and/or your dependant(s) only if covered for similar benefits under spouse's plan.

Refusal of Extended Health/Dental I do not want coverage for: ◯ Single ◯ Family Date of refusal (dd/mmm/yyyy) _____

Some plans allow refusal of certain benefits if the plan member has coverage under their spouse's plan. If you wish to add coverage at a later date, you may reapply for these benefits at which time satisfactory medical evidence may be required.

6 Coordination of benefits

This section is required if you are applying for coverage on your dependants.

Do you or your dependants (spouse and/or children) have benefit coverage under another benefits plan? ◯ Yes ◯ No

If *yes*, please provide the following details: Name of other insurer _____

Insured's last name _____ First name _____ Date of birth (dd/mmm/yyyy) _____

Effective date of coverage (dd/mmm/yyyy) _____ Identification/certificate number _____ Policy number _____

Please indicate type of coverage under other plan:

In cases where the information is not complete, a default value of Secondary will be applied.

Extended Health Benefits	Dental Care
◯ Single	◯ Single
◯ Couple	◯ Couple
◯ Family	◯ Family
◯ None	◯ None

Continued on the next page.

7 Dependant information

Spouse

If there is not enough room to list your dependants, attach details on a separate sheet.

Complete the following section if the plan includes health and/or dental coverage and you have not refused benefits for your dependants in Section 5, Refusal of benefits.

Last name _____ First name _____ Date of birth (dd/mmm/yyyy) _____

Gender ◯ Male ◯ Female If common law, please provide the effective date of cohabitation (dd/mmm/yyyy) _____

*To apply for over-age disabled dependant coverage, please complete form GL0514E.

Last name	First name	Date of birth (dd/mmm/yyyy)	Gender Male	Gender Female	Over-age student	Over-age disabled dependant*
			◯	◯	◯	◯
			◯	◯	◯	◯
			◯	◯	◯	◯
			◯	◯	◯	◯
			◯	◯	◯	◯
			◯	◯	◯	◯

8 Banking information and email address

NOT Applicable Do not complete

9 Authorization and consent

I hereby apply for coverage ("Coverage") under the Group Benefits plan issued to my plan sponsor by Manulife. **I understand** that certain aspects of such Coverage may extend to my spouse and eligible dependants (collectively, "Dependants"). **I certify** that the information in this form is true and complete to the best of my knowledge. **I understand** that as the applicant, it is my responsibility to ensure that any further verbal or written statement provided by me, and/or my Dependants, in the future is true and complete to the best of our knowledge. **I acknowledge and agree** that this Coverage or any portion of this Coverage, and future claims thereunder may be denied or terminated as a result of the provision of false, incomplete, or misleading information. **I authorize** Manulife to collect, use, maintain and disclose personal information relevant to this application ("Information") for the purposes of Group Benefits plan administration, audit, assessment, investigation, claim management, underwriting and for determining plan eligibility ("Purposes"). **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with Manulife, its reinsurers and/or its service providers, for the Purposes. **I am authorized** by my Dependants to consent to this Authorization, on their behalf as if they were signing it themselves, and to disclose and receive their Information, for the Purposes. **I authorize** my plan sponsor to make deductions from my pay for my Group Benefits plan, if applicable. **I authorize** the use of my Social Insurance Number ("SIN") for the purposes of identification and administration, if my SIN is used as my plan member certificate number. **I agree** a photocopy or electronic version of this authorization is valid.

If applicable, **I authorize** Manulife to deposit all payments ("Payments") due to me from the above referenced Group Benefits policy ("Policy"), into the bank account ("Account") that I have identified on this form. **I confirm** that this direct bank deposit authorization applies to the financial institution herein named by me and any other financial institution I choose to name in the future; and shall remain valid until revoked in writing by me, or my duly authorized representative.

I understand and agree that upon the deposit of any Payment(s) into the Account, Manulife is fully discharged from any further liability with respect to such Payment(s). **I also understand and agree** that Manulife may, at any time and without prior notice, discontinue the direct deposit of Payment(s), as requested herein, and require my personal written endorsement relating to future Payment(s). **I also hereby acknowledge and agree** that any Payment(s) made by Manulife into the Account, to which I am not entitled, either by contract or by law, shall not form part of my property, and shall be immediately refunded to Manulife, either by me or by representatives of my estate.

If applicable, **I authorize** Manulife to correspond with me through the email address identified on this form regarding my Coverage, for the Purposes. **I understand** such correspondence may contain Information; and that the Information is being sent in a manner that is not guaranteed as a secured means of communication. **I agree** that Manulife is not liable for damages which I may incur as a result of interception by a third party of an email transmission sent by Manulife or by me pursuant to this authorization. **I agree** should the email address identified on this form change that I am responsible for updating the email address maintained by Manulife. **I understand** that if I do not wish to receive emails from Manulife, I can remove my email address online or by contacting the Customer Service Centre.

I understand that any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a Group Benefits life, health or disability file. Access to my Information will be limited to:

- Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs;
- persons to whom I have granted access; and
- persons authorized by law.

I have the right to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected.

I acknowledge that more specific details regarding how and why Manulife collects, uses, maintains, and discloses my personal information can be found in Manulife's Privacy Policy and Privacy Information Package, available at www.manulife.ca/planmember, or from my Plan Sponsor.

PLEASE SIGN HERE Signature of plan member _____ Date signed (dd/mmm/yyyy) _____

10 Mailing instructions Please return the completed form to your Plan Administrator.

Manulife

Please see reverse for assistance in completing this form.
Please send the completed form to your Plan Administrator.

Group Benefits Beneficiary Designation

All sections of this page should be completed as it will replace any prior designations.

1 Plan member information

Plan sponsor name	Plan contract number	Plan member certificate number
Sinai Health System	**01489**	
Plan member name (last, first and middle initial)	Province of residence	Date of birth (dd/mmm/yyyy)

2 Primary beneficiary

List all primary beneficiaries for Basic Life and/or Basic Accidental Death.

Percentages must total 100% to be valid.

Name of beneficiary (last, first and middle initial)	Date of birth (dd/mmm/yyyy)	Relationship to plan member	Percentage
			%
			%
			%

3 Optional coverage

Plan contract number

NOT APPLICABLE

Name of beneficiary (last, first and middle initial)	Date of birth (dd/mmm/yyyy)	Relationship to plan member	Percentage
			%
			%
			%

4 Contingent beneficiary

You may wish to designate a contingent beneficiary(ies) to receive any proceeds under this group policy if all of the primary beneficiary(ies), named above for either coverage, should die before you. In that event, a contingent beneficiary will automatically be entitled to the benefit that would have been payable to the primary beneficiary(ies). If you name more than one contingent beneficiary, then the proceeds will be split, evenly, amongst the contingent beneficiaries you choose to name. Should there not be any surviving beneficiaries at the time of your death, the proceeds will be paid to your estate.

Name of contingent beneficiary (last, first and middle initial)	Date of birth (dd/mmm/yyyy)	Relationship to plan member
Name of contingent beneficiary (last, first and middle initial)	Date of birth (dd/mmm/yyyy)	Relationship to plan member

5 Trustee appointment

Complete if any beneficiary named is under the age of majority.

I appoint _____ as Trustee to receive any amount due to any beneficiary under the age of majority (not applicable in Quebec).

6 Declaration and authorization

Due to the legal significance of a beneficiary appointment this designation must be signed and dated to be valid.

A copy, fax, scan or image of the beneficiary designation in this form is as valid as the original.

I hereby revoke any previous beneficiary designations in relation to my foregoing coverage(s) and designate the person(s) named above.

At Manulife, we know that confidentiality of personal information is important. Any information you provide to us will be kept in a Group Life and Health Benefits file. Access to your information will be limited to:

- our employees and service representatives in the performance of their jobs;
- persons to whom you have granted access; and
- persons authorized by law.

You have the right to request access to the personal information in your file and, if necessary, correct any inaccurate information.

I acknowledge that more detailed information concerning how and why Manulife collects, uses and discloses my personal information is available at www.manulife.ca/planmember, or by requesting a copy from my plan sponsor.

Plan member signature	Date signed (dd/mmm/yyyy)

Manulife assumes no responsibility for the validity or sufficiency of the content provided by you. The items 'you' and 'yours' refer to the plan member, the term "Plan Sponsor" refers to the entity that offers the group benefits plan, such as an employer.

What is the purpose of a beneficiary?

If you intend for some or all of your death benefit to go to specific individuals, it is important to make sure that you plan ahead and select those beneficiaries. Having an up-to-date beneficiary designation will make this possible by listing your primary and contingent beneficiaries and intended allocations.

Beneficiary: the person, people or entity who will receive any death benefit from the basic or optional coverage you have selected through your group benefits plan that becomes payable upon your death. Basic and optional beneficiaries may differ.

Types of beneficiary – Primary vs. Contingent

Primary: the person, people or entity you choose to receive the death benefits. If you choose more than one beneficiary, you will need to indicate what percentage of the benefit you would like each person to receive. When multiple primary beneficiaries are named, the total of the percentages allocated to each primary beneficiary must add up to 100%.

Contingent: the person, people or entity you designate to receive the death benefits if all of the primary beneficiaries die before you. If you select more than one contingent beneficiary, the benefit will be split evenly between the contingent beneficiaries.

What happens to the death benefit when. . .

The primary beneficiary dies before you and no contingent beneficiary is named.	The death benefit will be paid to your estate.
The primary beneficiary dies before you, but there is a contingent beneficiary(ies) designated.	The benefit will be paid to the contingent beneficiary(ies).
You assign two primary beneficiaries, and one beneficiary dies before you, and you have not updated your beneficiary form information.	The entire death benefit that would have been paid to the deceased beneficiary will be paid to the surviving primary beneficiary.

Irrevocable vs. Revocable

Irrevocable: the beneficiary you choose cannot be changed without the written permission of that individual.
For example, if you choose your spouse or partner to be the designated beneficiary and you end up separating, you will not be able to change the beneficiary designation without a completed release form from them.

In Quebec, naming your spouse (must be a civil union) as a beneficiary automatically means that he/she is an irrevocable beneficiary, unless you specify otherwise or divorce.

Revocable: a revocable beneficiary means that the beneficiary you choose can be changed at any time without the permission of that individual.
For example, if you choose your spouse or partner to be the designated beneficiary and you end up separating, you can then change that beneficiary designation without asking for that person's permission.

Naming a minor as a beneficiary

If a benefit becomes payable to a minor who is named as a primary or contingent beneficiary, the benefit can only be paid on behalf of the minor to a trustee or guardian for property, otherwise it will be paid into court to be held until the beneficiary has reached the age of majority for your specific province. It is important therefore, if you are choosing a beneficiary who is a minor at the time of the designation to also name a trustee.

If you are a Quebec resident, the parents are considered tutors of their child.

If a minor has been designated as an irrevocable beneficiary, the policy is automatically frozen until the beneficiary has reached the age of majority for your specific province. A parent, guardian or trustee cannot consent to a beneficiary change on behalf of a minor.

Minor: a person named as a beneficiary who is under the age of majority for your specific province.

Trustee: a person appointed by you to hold the minor's proceeds in trust until the minor reaches the age of majority for your specific province.

Tutor: a tutor acts like a trustee.

Hennick Bridgepoint Hospital
Sinai Health

DIRECT DEPOSIT APPLICATION

I, _____hereby authorize Hennick Bridgepoint Hospital, to deposit my wages every two weeks into the following bank account:

ATTACH BLANK VOIDED CHEQUE from your banking institution

HERE

(we cannot guarantee deposit if voided cheque or banking information is not supplied)

If you do not have a chequing account, please take this form to your bank for completion.
Primary Account:

_____ !___!___!___!
BANK NAME BANK CODE

_____ !____!____!____!____!____!
BANK ADDRESS TRANSIT NUMBER

_____ !____!____!____!____!____!____!____!____!____!____!____!
ACCOUNT NUMBER

If you have a second account, please complete the information below.

Secondary Account: Please deposit $_____ to this account.

_____ !___!___!___!
BANK NAME BANK CODE

_____ !____!____!____!____!____!
BANK ADDRESS TRANSIT NUMBER

_____ !____!____!____!____!____!____!____!____!____!____!____!
ACCOUNT NUMBER

_____ _____
EMPLOYEE SIGNATURE DATE

For HR Use Only:
Entered in by: _____ Date: _____

Verified by: _____ Date: _____

IN THE EVENT OF CHANGING BANKING ACCOUNTS, PLEASE NOTIFY HUMAN RESOURCES IMMEDIATELY – BRING A BLANK VOIDED CHEQUE FOR THE NEW ACCOUNT

RETURN THIS FORM TO HUMAN RESOURCES ASAP

1 Bridgepoint Drive, Toronto, Ontario M4M 2B5 Telephone 416 461-8252 Fax (HR) 416-461-9972