

Health & Dental Benefit Trust

Enrollment Form

Company: _____ **Co. Year End:** _____

(The employer) To enroll in the Plan please complete Section One and have the employer complete Section Two.

Section One

Employee Name (please print) _____ Address _____ Date of Birth _____
Tel. _____ Day/Month/Year _____
Hm. _____
Bus. _____ City _____ Province _____ Postal Code _____

Listing of Dependents: Please list all dependents that will be covered under this plan.

Name of Dependent(s)	Relationship	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Dependents of an Eligible Employee are defined as follows:

- a) A spouse who is either;
 - 1. legally married to Employee: or
 - 2. A person of the opposite sex who is living with the Employee and who is publicly represented as the Employee's spouse; and
- b) Any member of the employee's household with whom the employee is connected by blood relationship, marriage or adoption.

I wish to participate in the Cost Plus Benefit Plan and the information above is correct.

Date _____ Employee Signature _____
_____ X _____
Day/Month/Year

Section Two

I hereby confirm that the employee mentioned above is an eligible employee

Eligibility Effective Date: _____ Authorized Employer Signature _____
_____ X _____
Day/Month/Year

Employer Approval

"One Time" Enrollment Fee \$150.00

Mail or Fax to: Ogden Financial Planners Ltd. Trust
13 Aspen Meadows Heath S.W.
Calgary, AB T3H 5Z6
Fax: 228-0926