**Writing Progress Check**

**Task**

One of the forms that new full-time employees need to fill out is an Employee Health Benefits

form. This form is necessary to get financial coverage to help pay medical and dental expenses while a person is employed at a company.

**Complete the following:**

1. Fill in the Employee Health Benefits form for Raja Rao, the new employee at CDN Malls.

Use his information below.

2. Use the rubric to help you complete the form.

 Raja S. Rao is married.

 He lives at 1234 Centre Street N in Calgary with his wife Shanti R. Rao.

 They do not have any children.

 Their postal code is T1A 2B3.

 Their phone number is 403‐222‐3434.

 Raja will be working at CDN Malls (403‐277‐6255).

 Raja is applying for family benefit status.

 Raja’s Provincial Health Care number is 12345‐6789.

 His wife’s Provincial Health Care number is 12345‐6780.

**Employee Health Benefits Form**

**Complete this form in block letters with black ink. Complete this section with your information:**



|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Surname | Given Name | | Middle Initial | DOB  YYYY‐MM‐DD |
| Address | | City | Province | Postal Code |
| Tel  H W | | Gender  □ Male □ Female | Provincial Health Care Number | |

**Complete this section with family information:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Type of Coverage  □ Single □ Family | Married  □ Y □N | | Number of Children | | |  | | |
| Spouse’s Information: | | | | | | | | |
| Surname | | Given Name | | | | Middle Initial | | DOB  YYYY‐MM‐DD |
| Address (if different from applicant) | | | City | | | Province | | Postal Code |
| Tel  H W | | | Gender  □ Male □ Female | | | Provincial Health Care Number | | |
| Children (under the age of 21) | | | | | | | | |
| Surname | Given Name and Middle Initials | | | Gender  M F | DOB  YYYY‐MM‐DD | | Provincial Health Care Number | |
|  |  | | |  |  | |  | |
|  |  | | |  |  | |  | |

**Complete this section with your signature: I certify that all the information on this form is true and complete. I give permission to Health Matters Insurance to use this information for my health coverage.**

Signature: Date:

**Do not write here. This section to be completed by the employer.**

|  |  |  |  |
| --- | --- | --- | --- |
| Plan Name | | Plan Number | Date of Coverage  YYYY MM DD |
| Occupation | Department | Employee Number | Hiring Date  YYYY‐MM‐DD |