

Chapter 1

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, a 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.



Health Matters
Insurance

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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Provincial Health Care Number	

Complete this section with family information:

Type of Coverage <input type="checkbox"/> Single <input type="checkbox"/> Family	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Provincial Health Care Number		
Children (under the age of 21)				
Surname	Given Name and Middle Initial(s)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	DOB YYYY-MM-DD	Provincial Health Care Number
		<input type="checkbox"/> M <input type="checkbox"/> F		
		<input type="checkbox"/> M <input type="checkbox"/> F		
		<input type="checkbox"/> M <input type="checkbox"/> F		

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:
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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