Print Form

Saint Francis Xavier University – Election Form

As of the August 1, 2019 changes to benefits at StFX University, I, _____

am applying for: Single ☐ Family ☐ coverage and have a spouse/partner who is also employed at Saint Francis Xavier University.

Will you or any of your dependents have coverage under any other Plan including StFX?

Yes ☐ No ☐

If Spouse/Partner is a StFX Employee, please complete the following:

Spouse/Partner Name: _____

Spouse/Partner Date of Birth (DD/MM/YYYY) _____

If there are family members with coverage under any plan other than StFX:

Name of the Other Insurer: _____

Effective Date of Coverage (DD/MM/YYYY): _____

Policy Number: _____ ID Number: _____

Type of Coverage: ☐ Hospital ☐ Vision ☐ EHB ☐ Drugs ☐ Dental ☐ All

Name of Employer/Plan:_____

Name of Person(s) insured under other policy	DOB		
	DD	MM	YYYY

Employee Signature: _____ Date:_____

Please scan completed form to benefits@stfx.ca by October 15, 2019