



Membership Application

2 Dartmouth Road, Bedford, NS, B4A 2K7
Phone (902) 832-8500 Fax (902) 832-8505
WWW.HEALTHASSOCIATION.NS.CA

ORGANIZATION INFORMATION

Name of Organization: _____

Legal (Incorporated) Name: _____

Street (courier) Address: _____

Postal Code: _____

Mailing Address (if different from above): _____

Phone: _____ Fax: _____

Number of Years in Business: _____

Website Address: _____

Social Media Sites (ie. Twitter, Facebook): _____

Total Number of Employees: _____

Number of Permanent Full Time Employees: _____

Number of Permanent Part Time Employees: _____

Number of Casual/Temporary Employees: _____

Number of Employees Enrolled in Group Benefits if Applicable: _____

If a unionized workforce, what is the number of unionized employees, number of collective agreements, and the name of your bargaining unit/union representation?

IDENTIFICATION OF ORGANIZATION TYPE

<input type="checkbox"/> Adult Residential Centre	<input type="checkbox"/> Home Support Agency
<input type="checkbox"/> Contract Service Provider	<input type="checkbox"/> Nursing Home
<input type="checkbox"/> Foundation	<input type="checkbox"/> Regional Rehabilitation Centre
<input type="checkbox"/> Group Home	<input type="checkbox"/> Residential Care Facility
<input type="checkbox"/> Home Care Agency	<input type="checkbox"/> Shared Service Provider
<input type="checkbox"/> Home for the Aged	<input type="checkbox"/> Other (specify) _____

NOVA SCOTIA HEALTH AUTHORITY ZONE (if applicable)

Central Northern Eastern Western

PRINCIPLE FUNDING

Department of Health & Wellness Department of Community Services Other

Operating Budget: \$_____

OWNERSHIP INFORMATION

Ownership Category:

Private/Proprietary Private/Non-Profit Public

Religious Order Municipal

Name of Owning Company: _____

Address: _____

Postal Code: _____

SENIOR MANAGEMENT TEAM

Name	Title	Phone	Fax	Email

FEE-FOR-SERVICE

Please indicate below the services which you are interested in accessing on a fee-for-service or cost-recovery basis:

Cost Recovery Services	
GROUP BENEFITS SOLUTIONS	<ul style="list-style-type: none">• Long Term Disability• Basic Life• Health• Dental• Optional Life, Critical Illness, and Accidental Death & Dismemberment• Employee Assistance Program (EAP) through Shepell·fgi
NOVA SCOTIA HEALTH EMPLOYEES' PENSION PLAN	
Fee-For-Service (Contract)	
CLINICAL ENGINEERING SERVICES	
LABOUR RELATIONS & COMPENSATION ANALYSIS	
FINANCIAL SERVICES	

GROUP BENEFITS INFORMATION

**(Must be completed even if you are not interested in purchasing Group Benefits Solutions at this time)*

Why are you applying to join Health Association Nova Scotia's Group Benefits Solutions at this time? (if applicable)

How many times have you changed carriers over the past five years?

Name _____

Signature _____

Position _____

MISSION, VISION, AND VALUES

I have read and support the Health Association's Mission Statement, Vision Statement, and Values.

Name	Title
(Administrator/CEO)	
Signature	Date
Name	Title
(Board Chair)	
Signature	Date

Membership in Health Association Nova Scotia is at the sole discretion of the Board of Directors. Failure to provide the above information may result in membership being declined.

MEMBERSHIP INFORMATION (To be completed by the Health Association)

Membership applications for Health Association Nova Scotia are approved by the Board of Directors. The Board has established a policy that sets out the criteria the Board considers when assessing the suitability of an applicant for membership.

Membership Status: Active Associate GPO

Date membership application approved: _____