Only complete this form if you do not need/want EHC/Dental coverage.
If you want coverage later you may be considered a late applicant.

BRITISH COLUMBIA PUBLIC SCHOOL EMPLOYERS' ASSOCIATION
SOLUTIONS AT WORK

Waiver of Coverage

Part 1: Employee Information

Employee's Last Name	First Name	Initial	District #	Employee ID#	Employee Group

Part 2: Waiver of Coverage

Before you sign this form, read the online benefit information available to you at www.bcpseabenefits.ca or ask your employer to explain the benefits to you. You should fully understand all the benefits and plan rules before waiving your coverage.

Section A – Waiver certified by employer (Employer Signature Required)

I understand the benefits available to me under the BCPSEA Buying Group for my District and acknowledge that I have been given an opportunity to apply for these benefits, and

I do not want coverage for the following: ❑ Dental ❑ Extended Health benefits for:

❑ Myself and my dependents ❑ My dependents only

Employer – I hereby certify that: minimum participation requirements, as stipulated in the contract, have been met; this plan requires employees/employers to contribute to the cost of coverage; benefit coverage is not a condition of employment.

Employer Signature_____ Date Signed_____

Section B – Waiver due to coverage under another plan

☐ My dependents and I have benefits under another plan, as indicated in Part 3 of my BCPSEA Enrolment form. I understand that we/I have the option of having coverage under more than one plan, but I have chosen to waive coverage under the BCPSEA Buying Group for:

❑ Myself and my dependents ❑ my dependents only for ❑ Dental; Policy Number#_____

❑ Myself and my dependents ❑ my dependents only for ❑ Extended Health; Policy Number#_____

Termination Date:_____

If the other plan terminates, I understand that there are time limits for applying for coverage. If I apply late, or if I apply while the other plan is still active, I understand that dental coverage may be restricted to $250 per person for the first year, and/or my dependents and I will have to provide evidence of good health, and the insurer may decline to cover me or my dependents.

Section C – Waiver due to leave of absence

☐ I am going on a leave of absence/Maternity/Parental/EI Compassionate Care Leave and have chosen to waive coverage under the BCPSEA Buying Group for my district during this period of time for the following list of benefits:

Please list benefit coverage to be waived:

_____

Termination Date:_____

I understand that if I waive long term disability benefits (if applicable) during my leave and become disabled, the disability will not be covered by the plan and no benefits will be paid at any time. Coverage will not be reinstated until I return to active employment.

Part 3: Employee Signature

I have been offered the opportunity to participate in the BCPSEA Buying Group plan. I have carefully studied the benefits and the plan rules, and I understand that if I apply at a later date for any benefit(s) that I am now waiving, as explained above, dental coverage may be restricted to $250 per person for the first year of coverage, and/or that I will be required to prove, at my own expense, that I and my dependents are in good health. My insurer reserves the right to refuse my application if my health or my dependent's health is not considered satisfactory.

Employee Signature_____ Date Signed_____