

LATE DEPENDENTS

BENEFITS CONTROL / WAIVER FORM - CUPE 947

You must complete and return this form together with the Benefits Change Form and Statement of Health

This form is used by the Payroll & Benefits Office to confirm which coverage you want. Please make sure all applications are dated and signed. If the attached applications are incomplete they will be returned and coverage may be delayed. Please print clearly.

Name: _____ Date: _____

Employee #: _____ School/Location: _____

If you are making benefit changes for any reason other than adding late eligible DEPENDENTS to your coverage, please contact the Payroll & Benefits Office for appropriate forms.

Late applications will be forwarded to Pacific Blue Cross for review. Pacific Blue Cross will determine if your dependents will be approved for coverage. If approved, they will determine the effective date of coverage.

Please indicate benefits you want your dependent(s) added:

Complete Public Education Benefits Trust Benefits Change Form and Statement of Health

____ **Extended Health** (Pacific Blue Cross)

____ **Dental** (Pacific Blue Cross)

Please complete all applicable fields of the forms before signing and returning the forms.

I have been fully advised by the Greater Victoria School District of the benefit plans and options available to me for coverage under these plans. I understand the plans and options available to me, and I have applied or waived coverage as described above.

Date: _____

Signature: _____

The information collected on this form is required and will be used by School District No. 61 solely for purposes of benefit plan administration. It will be kept secure and confidential in accordance with the Freedom of Information and Protection of Privacy Act. The information will also be used by the organizations that provide the benefits plans, as explained on the form that is used by the plan carrier. Any questions concerning the collection or use of this information by the School District may be addressed to: Payroll and Benefits Coordinator, Greater Victoria School District No. 61.



**Only complete this form if you are adding a
common-law spouse**

Common Law Spouse Declaration

Employee Common Law Spouse Declaration

Employee's Last Name, First Name

District #

Please insure my common law spouse, _____ for the following benefits as of _____:
(full name of common law spouse) (Coverage effective date)

☐ Extended Health Care

☐ Dental Care

Date co-habitation began: _____

Common law spouse definition: A person of the opposite or same sex, who has been residing with the Employee for a continuous period of at least 1 year, and is publicly represented as the Employee's spouse.

I hereby certify that my spouse meets the definition of common law spouse as defined above.

Employee Signature _____

Date Signed (yyyy/mm/dd) _____

The appropriate section(s) below should only be completed as changes to the Benefits Enrolment Form are required. Once completed, the benefits administrator should file this form for future reference.

Benefits Change Form

Part 1: Employee Identification									
Employee's Last Name			First Name		Initial	District #	Employee ID number	Provincial Health Plan Number (Care Card)	
Part 2: Change in Family Status									
Change of coverage requested due to the following "event":								Date of Event (yyyy/mm/dd)	
<input type="radio"/> Marriage <input type="radio"/> Cohabitation <input type="radio"/> Divorce <input type="radio"/> Separation <input type="radio"/> Death <input type="radio"/> Birth <input type="radio"/> Adoption									
<input type="radio"/> Other (specify):									
Revised Extended Health Coverage					Revised Dental Coverage				
<input type="radio"/> Single <input type="radio"/> Couple <input type="radio"/> Family <input type="radio"/> Waived (attach Waiver of Coverage form)					<input type="radio"/> Single <input type="radio"/> Couple <input type="radio"/> Family <input type="radio"/> Waived (attach Waiver of Coverage form)				
Add	Delete	No.	Dependent's First Name	Initial	Last Name (if different from Employee)	Birthdate (yyyy/mm/dd)	Relationship	Gender M – Male F – Female X – Another Gender U – Prefer Not to Disclose	Provide name of school and student number if child is over 21 and studying full-time. If child is disabled, indicate "disabled" in this section and attach the approved CRA/PWD (Persons with Disability) document. If adding an adopted child, provide date of adoption. If adding a legal ward, provide court document.
<input type="radio"/>	<input type="radio"/>								
<input type="radio"/>	<input type="radio"/>								
<input type="radio"/>	<input type="radio"/>								
<input type="radio"/>	<input type="radio"/>								
<input type="radio"/>	<input type="radio"/>								
Part 3: Change to Spousal or Other Coverage									
Change of <input type="radio"/> Dental <input type="radio"/> Extended Health coverage requested due to:								Date of Change (yyyy/mm/dd)	
<input type="radio"/> Spouse's plan terminated – enrol on PEBT plan (ensure Group Insurance Application is up to date or note additions on this form)									
<input type="radio"/> Transferring to Spouse's plan - terminate from PEBT plan by completing Waiver of Coverage Form. Spouse's policy number: _____									
Revised Extended Health Coverage:					Revised Dental Coverage:				
<input type="radio"/> Single <input type="radio"/> Couple <input type="radio"/> Family <input type="radio"/> Waived (attach Waiver of Coverage form)					<input type="radio"/> Single <input type="radio"/> Couple <input type="radio"/> Family <input type="radio"/> Waived (attach Waiver of Coverage form)				
Part 4: Change of Beneficiary Designation									
New Beneficiary - Last Name			First Name		Initial	Share of Proceeds %	Relationship	Name of Trustee for Beneficiaries Under 18	
						%			
						%			
						%			
To which benefit(s) does this change apply? <input type="radio"/> All applicable benefits, or: <input type="radio"/> Basic Life <input type="radio"/> Optional Life <input type="radio"/> Basic AD&D <input type="radio"/> Optional AD&D									
Part 5: Change of Name									
Previous Last Name			First Name		Initial	Date of Change (yyyy/mm/dd)			
New Last Name			First Name		Initial	<input type="radio"/> Employee <input type="radio"/> Dependent			

I hereby confirm the above information is complete, true and correct. I understand that if this application is completed more than 31 days after the loss of extended health and/or dental coverage through another plan, or 4 months after the addition of an eligible dependent that changes my family status, satisfactory evidence of insurability will be required to add dependents to this plan. I reserve the right to change my beneficiary at any time.

Employee Signature _____

Date Signed (yyyy/mm/dd) _____

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | 604 419-2000 or Toll Free 1 877 PAC-BLUE | Fax: 604 419-2149

i APPLICANTS — Please complete PART 2-7 of this application and return to enrollment@pac.bluecross.ca.
If applying for Optional Life coverage, please also complete a Beneficiary Designation form.
EMPLOYERS/PLAN ADMINISTRATORS — Please complete PART 1 of this application.

PART 1 — EMPLOYER/PLAN ADMINISTRATOR

Policy number	Name of company/organization	Member ID number	Date of hire/rehire (mm-dd-yyyy)
Reason for application <input type="checkbox"/> Late enrollment <input type="checkbox"/> Increase coverage <input type="checkbox"/> Annual re-enrollment		Who is this application for <input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent(s)	
Type of insurance and amount applying for			
<input type="checkbox"/> Life/Accidental death & dismemberment \$ _____	<input type="checkbox"/> Short-term disability \$ _____	<input type="checkbox"/> Member Optional Life \$ _____	
<input type="checkbox"/> Dependent life \$ _____	<input type="checkbox"/> Long-term disability \$ _____	<input type="checkbox"/> Spouse Optional Life \$ _____	
<input type="checkbox"/> Extended health care	<input type="checkbox"/> Critical illness \$ _____	<input type="checkbox"/> Member Optional Critical Illness \$ _____	
<input type="checkbox"/> Dental		<input type="checkbox"/> Spouse Optional Critical Illness \$ _____	

PART 2 — APPLICANT INFORMATION

Legal first name	Middle initial	Last name	Birthdate (mm-dd-yyyy)	Gender* <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> U <input type="checkbox"/> X
Country of birth	Occupation	Height	Weight	
Address		City	Province	Postal code
Email		Phone number	Fax	

Physician and medical records

Please select one of the following and complete the details below accordingly
☐ Below is my primary physician's information ☐ I don't have a primary physician, but the clinic below has my records

Physician's first name	Physician's last name	Clinic name
Address		City
		Province
		Postal code
Email		Phone number
		Fax

PART 3 — ADDITIONAL INDIVIDUALS TO BE COVERED

Only fill out part 3 if there are additional individuals that you are applying for.

Spousal information

Legal first name	Middle initial	Last name	Birthdate (mm-dd-yyyy)	Height	Weight
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Dependent(s) information**Dependent 1**

Legal first name	Middle initial	Last name	Birthdate (mm-dd-yyyy)	Gender* <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> U <input type="checkbox"/> X
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Dependent 2

Legal first name	Middle initial	Last name	Birthdate (mm-dd-yyyy)	Gender* <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> U <input type="checkbox"/> X
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Dependent 3

Legal first name	Middle initial	Last name	Birthdate (mm-dd-yyyy)	Gender* <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> U <input type="checkbox"/> X
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Dependent 4

Legal first name	Middle initial	Last name	Birthdate (mm-dd-yyyy)	Gender* <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> U <input type="checkbox"/> X
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*F = Female, M = Male, U = Prefer not to disclose, X = Another gender

PART 4 — GENERAL DECLARATION

		MEMBER	SPOUSE
1. Have you or your spouse used any form of tobacco, tobacco cessation products, nicotine, e-cigarettes, or nicotine replacement products in the last 12 months? If yes, provide details (Member) _____ If yes, provide details (Spouse) _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has your weight decreased more than 4.5 kg or 10 lbs in the past year?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Member	If yes, how much weight was lost? _____ Reason(s) for weight loss _____		
Spouse	If yes, how much weight was lost? _____ Reason(s) for weight loss _____		
3. Have you or your dependents ever applied for or received benefits, compensation, or pension due to injury or disability? If yes, provide details. If yes, provide details (Member) _____ If yes, provide details (Spouse) _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependents Fill this out if this applies to 1 or more of your dependents. You do not need to identify which dependent. <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide details _____			

PART 5 — MEDICAL DECLARATION

5.1 Have you, your spouse or dependent(s) consulted a physician, been treated for or have/had any known indication of any of the following medical conditions? If you are unsure how to answer any of these questions, please consult your doctor.

If you answer yes to any section in question 5.1 and/or 5.2, please complete question 5.4.

	MEMBER (YOU)	SPOUSE	DEPENDENT(S)
a) Cardiovascular or circulatory including vascular disease, high blood pressure, elevated cholesterol, heart attack, angina, stroke or TIA (mini-stroke) and blood disorders.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Diabetes / Endocrine disorders including Type 1 or Type 2, hormonal or thyroid conditions.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Gastrointestinal conditions including stomach, intestinal or liver conditions (including hepatitis A, B, C or B carrier state), Colitis, Crohn's disease, Irritable Bowel Syndrome, Diverticulitis, Colon polyps, Ulcers, Hernia, GERD (acid reflux or persistent heartburn).	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Respiratory or Lung conditions including Allergies, Asthma, Bronchitis, Chronic Obstructive Pulmonary Disease (COPD), Sleep Apnea.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Musculoskeletal conditions including Osteoarthritis or Rheumatoid Arthritis, Osteoporosis, bone density loss or back, neck, limb or joint pain (including Fibromyalgia).	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) Immunological conditions including being tested for, counselled for, treated for or told you have AIDS (Acquired Immune Deficiency Syndrome), HIV (Human Immunodeficiency Virus) or any other immunological disorder.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g) Genitourinary conditions including kidney, bladder, infertility or Reproductive Disorders, Menopause, Endometriosis, Sexually Transmitted Disease(s) or recurring infections (cold sore/ Herpes/Shingles).	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h) Neurological conditions including Alzheimer's, Dementia, Parkinson's, epilepsy, Multiple Sclerosis, Seizures, Paralysis, chronic headaches or migraines, or Chronic Fatigue Syndrome.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i) Mental or Nervous conditions including Anxiety, Depression, Emotional Disorders, Eating Disorders, Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD).	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j) Cancer and Tumors including malignant or benign, leukemia.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
k) Drugs including ever used narcotics, stimulants, hallucinogens or other drugs except those that were prescribed by a physician.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

PART 5 — MEDICAL DECLARATION (continued)

		MEMBER (YOU)	SPOUSE	DEPENDENT(S)
5.2 Within the past five years, have you had any medical conditions not already mentioned on this form or abnormal test results?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.3 Do you currently have a referral, testing, treatment or investigation pending or contemplated but not yet completed, or are you aware of any symptoms or problems that require medical attention? If yes, provide details _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.4 If you answered YES to any part of question 5.1 and/or 5.2, please provide details. Please use one section per condition/disorder, even if an individual has multiple conditions/ disorders.				
Name of individual	Diagnosis date (mm-dd-yyyy)	<input type="checkbox"/> Same physician as in part 2.3		
Condition/disorder		Physician name		
Medication/treatment		Address		
Recovery date (mm-dd-yyyy)		Email	Phone number	
Name of individual	Diagnosis date (mm-dd-yyyy)	<input type="checkbox"/> Same physician as in part 2.3		
Condition/disorder		Physician name		
Medication/treatment		Address		
Recovery date (mm-dd-yyyy)		Email	Phone number	
Name of individual	Diagnosis date (mm-dd-yyyy)	<input type="checkbox"/> Same physician as in part 2.3		
Condition/disorder		Physician name		
Medication/treatment		Address		
Recovery date (mm-dd-yyyy)		Email	Phone number	

If there aren't enough sections in 5.4, please add details to the box below. Include the name of the individual (i.e., your name, spouse, or a dependent), conditions/disorders, diagnosis date, medication/treatment, and physician information.

5.5 Are you, your spouse or dependents taking any other prescribed medication(s) that you have NOT already disclosed above? If yes, provide name of medication(s) and reason below. Please use one section per individual, even if the individual is using multiple medications.

Name of individual	Medication(s)
Dosage	Frequency
Reason(s) for medication	
Name of individual	Medication(s)
Dosage	Frequency
Reason(s) for medication	
Name of individual	Medication(s)
Dosage	Frequency
Reason(s) for medication	

PART 5 — MEDICAL DECLARATION (continued)

If there aren't enough sections in 5.5, please add details to the box below. Include the name of the individual (i.e., your name, spouse, or a dependent), name of medication(s), dosage, frequency and reason(s) for medication.

5.6 Please identify any biological parents or siblings of yourself and/or your spouse who before the age 60, have ever had cancer, heart or kidney disease, mental or nervous disorder or any inheritable disorder (such as Huntington's chorea or polycystic kidney disease).

INDIVIDUAL	DETAILS OF THE CONDITION
Member's parent 1	
Member's parent 2	
Member's sibling	
Member's sibling	
Spouse's parent 1	
Spouse's parent 2	
Spouse's sibling	
Spouse's sibling	

PART 6 — DECLARATION AND AUTHORIZATION

I, the undersigned, declare that the answers to the above questions and the questions on the reverse of this form are complete and accurate and form part of an application for coverage with Blue Cross Life Insurance Company of Canada (Blue Cross Life) and/or Pacific Blue Cross. The information provided herein and collected in the future as part of the application process will be kept confidential and secure. This information will be used to determine eligibility for coverage, to administer the terms of my policy, to recommend suitable products and services to me and to manage the company's business. For these purposes, I (i) authorize any physician, health practitioner, hospital, clinic, pharmacy, or other medical or medically related facility, insurance company, government or regulatory authority, the MIB, LLC, or other organization, institute or person, that has any records or knowledge of me/my child or my/their health, to give Blue Cross Life, Pacific Blue Cross or their reinsurer any such information and (ii) Blue Cross Life and Pacific Blue Cross to access and use relevant information in records that they already hold about me.

I further authorize Blue Cross Life and Pacific Blue Cross to disclose this information to each other, their reinsurer or to any third party when required to determine eligibility of the application. Medical information may also be released to my/my child's personal physician or other medical practitioner. I have received and read the enclosed notice form describing the procedures of the MIB, LLC. I authorize Blue Cross Life and/or Pacific Blue Cross, or its reinsurer, to make a brief report of my personal health information to the MIB, LLC.

This consent is valid for as long as the contract is in force unless I revoke it in writing. I understand I may revoke my consent at any time; however, if consent is withheld or revoked the coverage may be denied or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent. If I have questions about the collection, use or disclosure of my or my dependent's personal information, I can visit <https://www.pac.bluecross.ca/privacy>. A photocopy of this authorization shall be as valid as the original.

Member signature X	Date (mm-dd-yyyy)
Spouse signature X	Date (mm-dd-yyyy)

PART 7 — MIB, LLC PRE-NOTICE

⚠ IMPORTANT: Please read carefully.

Information regarding your insurability will be treated as confidential. Blue Cross Life Insurance Company of Canada or its reinsurers may, however, make a brief report thereon to MIB, LLC. which operates an information exchange on behalf of insurance companies that are members of MIB Group Inc. If you apply to another MIB, LLC member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, LLC, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the MIB, LLC. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB, LLC's files, you may contact the MIB, LLC and seek a correction. The address of the MIB LLC's information office is: MIB, LLC 50 Braintree Hill Park, Suite 400 Braintree, MA 02184-8734. Telephone: 1 866 692-6901. www.mib.com

Blue Cross Life Insurance Company of Canada or their reinsurer may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

CUPE 947 BENEFIT COSTS

Premiums are subject to carrier rate changes

July 2024

		<u>Monthly Premium</u>	<u>Employee Deduction</u>	<u>Board Share</u>
<u>Premiums - September to June</u>				
Extended Health	Pacific Blue Cross (Group # 53748)			
	Single	105.59	0%	105.59 (100%)
	Couple	190.06	0%	190.06 (100%)
	Family	242.85	0%	242.85 (100%)
Dental	Pacific Blue Cross (Group # 53748)			
	Single	72.96	18.24 (25%)	54.72 (75%)
	Couple	143.86	35.96 (25%)	107.90 (75%)
	Family	209.89	52.47 (25%)	157.42 (75%)
Basic Life				
	Pacific Blue Cross (Group # 53748)	.1400 per \$1,000	0%	100%
	Compulsory			
Basic AD&D				
	AIG (Group # BSC 9104906)	.007 per \$1,000	0%	100%
	Compulsory			
Optional Life				
	Pacific Blue Cross (Group # 53748)	individual premiums see brochure for rates	100%	0%
Optional AD&D				
	AIG (Group # PAI 9104940)	individual premiums see brochure for rates	100%	0%

Summer Premiums - July & August:

Extended Health	Single	105.59	100%	0%
	Couple	190.06	100%	0%
	Family	242.85	100%	0%
Dental	Single	72.96	75%	25%
	Couple	143.86	75%	25%
	Family	209.89	75%	25%

10, 10 1/2 & 11 month employees are responsible for 100% of the Extended Health and 75 % of the Dental premiums for Summer months.

Please review the Summer Benefits sheet for Summer Premium calculations.

*on a PLOA, or Educ Leave, or Parenthood Leave, or LTD > 2 years, or UnPd Medical Lv > 6 months: EHC + Dental Summer Premiums are 100% employee paid.



CUPE 947 BENEFITS

PLEASE KEEP THIS INFORMATION FOR REFERENCE

For benefit information, please visit the following website:

PEBT (Public Education Benefit Trust)

www.pebt.ca

Please familiarize yourself with details on the website as changes may affect your coverage.

BENEFIT ELIGIBILITY DATE / COVERAGE START DATE

Employees will be enrolled onto the PEBT compulsory benefit coverage. Benefit coverage will be set up the 1st of the month following the benefit eligibility date.

Benefit eligibility dates include:

- Date employee completes the probationary period and is in an assignment of 20 hours or more per week
- Date weekly hours increase from below 20 hours to 20 hours or more
- Date other Extended Health or Dental coverage cancels e.g. spousal coverage

10 & 11 month employees who pass probation in June and will not be working during the summer months will have the start of coverage delayed until the first day of the month following the date they return to work.

EMPLOYEES MUST BE ACTIVELY WORKING AT THE START OF COVERAGE

The effective date of coverage will be delayed if employees are not actively working.

EXTENDED HEALTH, BASIC LIFE, BASIC AD&D and LTD (LONG TERM DISABILITY)

- Single Extended Health, Basic Life, Basic AD&D and LTD coverage are compulsory and will be automatically set up for all eligible employees
- Employees must maintain an assignment of 17.5 hours per week or more to continue Basic Life and AD&D coverage
- Employee must maintain an assignment of 15 hours per week or more to continue with LTD coverage. LTD coverage terminates at age 65.

DENTAL

Dental coverage is not compulsory. Employees are required to pay 25% of the monthly premiums in the school year. Employees who do not enroll on Dental when eligible, may not qualify at a later date.

EMPLOYEES MUST COMPLETE THE PEBT BENEFITS ENROLMENT FORM

Employees must complete Part 2, 3, 5 and 6 of the application form. Part 4 should only be completed if employees are waiving coverage.

WAIVING EXTENDED HEALTH COVERAGE

Employees may only waive Extended Health coverage if they are currently enrolled on other coverage. When completing the PEBT Benefits Enrollment Form, employees must indicate in Part 4 - Waiver of Benefits that coverage is not required. Employees Must also complete the *Waiver of Coverage* Form

WAIVING DENTAL COVERAGE

Employees may waive Dental coverage but may not qualify at a later date. When completing the PEBT Benefits Enrollment Form, employees must indicate in Part 4 - Waiver of Benefits that coverage is not required.

SUMMER PREMIUMS FOR 10, 10.5 AND 11 MONTH EMPLOYEES

Please refer to the *CUPE 947 Summer Benefits* explanation sheet to determine the cost of your summer benefits. Employees should realize that if benefit coverage starts during the school year, summer premiums will be larger than usual for the remainder of the school year. **Coverage cannot be canceled for only summer months and reinstated in the school year.**

CONFIRMATION OF COVERAGE

Employees will receive a Pacific Blue Cross ID card confirming coverage. Claims may be rejected if employees use coverage before receiving confirmation of coverage or submit claims dated prior to the effective date of coverage.

OPTIONAL COVERAGE

Employees may apply for the Optional Life and/or Optional AD&D coverage by completing the separate application forms available on the PEBT website. There are no enrollment deadlines for the optional coverage.

Optional AD&D applications will automatically be approved. Coverage starts the first day of the month following receipt of the application in the Payroll & Benefits office.

Optional Life applications should be returned to the Payroll & Benefits Office. The Payroll & Benefits Office will forward applications to the Carrier for approval. If additional information is required the Carriers will contact the employees directly.

EXTENDED HEALTH, DENTAL AND BENEFICIARY CHANGES

After the initial coverage is set up, employees may change the status of their coverage (add or delete dependents) or change beneficiaries by completing the PEBT Change Form. Changes are subject to carrier restrictions. Dependent eligibility and change forms are available through the Payroll & Benefits Office.

CUPE 947 BENEFIT FAQs

WHAT IS MY BENEFIT ELIGIBILITY DATE?

- Date employee completes the probationary period and is in a regular assignment of 20 hours or more per week
- Date weekly hours increased from below 20 hours to 20 hours or more
- Cancellation date of other benefit plans (e.g. spousal plans)

WHEN DOES BENEFIT COVERAGE START?

Extended Health Care and Dental coverage starts the first day of the month following your benefit eligibility date. The Basic Life and AD&D coverage starts on your eligibility date.

For example:	Benefit eligibility date:	April 24
	Basic Life & AD&D coverage starts:	April 24
	Extended Health Care & Dental coverage starts:	May 1

WHEN ARE MY DEPENDENTS ELIGIBLE FOR COVERAGE?

Dependents are eligible for coverage without restriction provided they apply when first eligible. If they apply at a later date, they must apply as a Late Applicant.

The eligibility date for a spouse is the later of:

- the date of marriage
- for a common-law spouse, the date the cohabitation period of 1 year is met
- Cancellation date of other benefit plans (e.g. spousal plans)
- the date the employee becomes eligible for coverage

The eligibility date for a dependent child is the later of:

- the date of birth
- the date the child becomes a dependent of the employee
- the date a spouse becomes eligible, in the case of the spouse's children
- the date the employee becomes eligible for coverage
- Cancellation date of other benefit plans (e.g., spousal plans)

CAN I HAVE DUAL COVERAGE?

The School District plans allows dual coverage, provided you apply when you are eligible (see benefit eligibility listed above).

CUPE 947 BENEFIT FAQs

WHAT IS A “LATE APPLICANT”?

If you and/or your dependents do not apply when first eligible and wish to apply at a later date (> 4 months after your benefits eligibility date), you will be considered a Late Applicant.

Employees and/or dependents who waive benefits coverage on a leave have until 30 days after returning to work to apply as a regular applicant. Applying >30 days, Employees will have to apply as a late applicant.

As a Late Applicant, the following are required:

Extended Health Care: An application form and medical questionnaire must be completed. These are signed and submitted by the Payroll & Benefit Office to the insurance carrier for approval/decline. If approved, the insurance carrier determines the effective date of coverage.

Dental: An application form must be completed. There is a \$250 restriction on Dental expenses for the first year. Coverage will be effective the date the carrier receives your application forms.

IF MY SPOUSE’S (OR OTHER COVERAGE) IS TERMINATING, CAN I APPLY TO HAVE COVERAGE?

Employees and/or dependents who experience a loss of other benefit coverage have until 30 days after plan termination to apply as a regular applicant. Applying >30 days, Employees and/or dependents who experience a loss of other benefit coverage will have to apply as a late applicant.

Extended Health Care and Dental

You must complete the application and the Transfer of Extended Health Care and Dental Coverage sheet. The Carrier needs to know why you are eligible for enrollment. The Transfer form must be completed by the other plan’s benefit administrator or a letter from your other plan’s benefit administrator outlining coverage details (as per transfer sheet) can be accepted.

WILL I RECEIVE ID CARDS FROM THE CARRIERS?

Yes, you will receive ID cards from Pacific Blue Cross containing your group number and ID number. Cards are also available on your Online PBC profile <https://service.pac.bluecross.ca/member/login/>

WHEN CAN I START USING MY PLANS?

Once you receive your Pacific Blue Cross ID cards indicating that coverage is in place.

WHEN CAN I APPLY FOR OPTIONAL COVERAGE?

You can apply for Optional Life and Optional AD&D coverage at any time. All Optional Life applications are sent to the carrier for review. The carrier determines whether or not your application will be approved; and if approved, the effective date of coverage.

CUPE 947 BENEFIT FAQS

WHAT IS COVERED UNDER THE EXTENDED HEALTH CARE AND DENTAL PLANS?

To determine which expenses are covered under the Extended Health Care and Dental plans, please visit the PEBT website www.pebt.ca. If you require clarification for expense reimbursements, please contact Pacific Blue Cross directly at **1-888-275-4672**.

HOW DO I MAKE AN EXTENDED HEALTH CARE CLAIM?

The Extended Health Care plan includes a pay-direct drug option. Present your Pacific Blue Cross ID card at the pharmacy and your pharmacist will submit the claim directly to Pacific Blue Cross. You only pay for the amount not covered under the plan.

For all other Extended Health Care claims, pay upfront and submit a completed claim form and the original receipts directly to Pacific Blue Cross. It is recommended that you keep copies of your claim form and receipts as original receipts will not be returned.

Claim forms can be found on the Pacific Blue Cross Plan Member website:

<https://www.pac.bluecross.ca/popups/member-forms/>

In addition, some claims may now be submitted online through your PBC Member Profile. For more information please visit: <https://www.pac.bluecross.ca/advicecentre/story/howto-claimonline>

For other claim questions please contact PBC at **1-888-275-4672**.

WHERE DO I GET DENTAL CLAIM FORMS?

Dental claims forms are usually submitted directly to Pacific Blue Cross by your dentist. Any outstanding cost is paid directly to the dentist.

WHO DO I CONTACT IF I HAVE A CONCERN ABOUT MY COVERAGE?

If you have any questions regarding what is covered or what can be claimed under your Extended Health Care and Dental plan, please contact Pacific Blue Cross at **1-888-275-4672**.

To verify information, please have your Pacific Blue Cross ID card handy.

WHO DO I CONTACT IF I WANT TO ENROLL OR MAKE CHANGES TO MY COVERAGE?

If you want to apply for coverage, make changes or terminate coverage, contact the Payroll and Benefits Office at 250-475-4201.



OVERAGE DEPENDENT STUDENTS

AGE RESTRICTIONS FOR DEPENDENTS

Extended Health and Dental have age restrictions for dependent children. Once a dependent reaches the age limit, the carrier will forward a form to determine if the dependent can remain on coverage. If the dependent is attending a recognized school, college or university, is not in a common-law relationship or marriage and is financially dependent on the parent(s), the dependent may be covered as an "overage" dependent until the age listed below.

The following are the age restrictions for medical, extended health and dental:

	Dependent to age:	Overage dependent to age:
Extended Health (PBC)	21	25
Dental (PBC)	21	25

CONTINUATION OF COVERAGE FOR OVERAGE DEPENDENT

Extended Health and Dental (PBC)

When the dependent reaches age 21, we will forward a student confirmation form to determine the eligibility of the dependent. If the dependent is eligible, forms must be completed and returned to the Payroll & Benefits Office. If forms are not received by the requested date, coverage will be cancelled on the last day of the child's birth month. Dependents needing individual coverage, should contact PBC directly.

Once a dependent is set up for coverage as an overage dependent, we will forward forms on an annual basis verifying eligibility. To avoid a break in coverage or loss of coverage, it is very important that the forms are completed in full and returned to the Payroll & Benefits office immediately.

January 2024



C U P E 947 SUMMER BENEFITS

TO DETERMINE THE COST OF SUMMER PREMIUMS FOR 10, 10 ½ & 11 MONTH EMPLOYEES,
PLEASE READ THIS INFORMATION AND COMPLETE THE CALCULATION SECTION TO
DETERMINE YOUR SUMMER PREMIUM DEDUCTION.

Premiums for Extended Health and Dental are prepaid for the summer months through monthly deductions during the school year.

12 Month Employees

12 month employees are not required to pre-pay summer premiums. Benefit premiums will be deducted from the last pay of each month.

10, 10 ½, & 11 Month Employees

Employees who work less than 12 months of the year are responsible for 100% of the Extended Health benefit premiums, and 75 % of the Dental Premiums for the summer months (July and August). Please refer to the Benefit Cost Sheet for monthly premiums. Employees who start coverage after September will have benefit calculations divided over the remainder of that school year. Please see calculation for employees starting benefit coverage during the school year.

Summer premiums are calculated and deducted from the 1st pay of every month during the school term (September to June).

Examples:

10 Month Employees must pay for 2 months of summer premiums:

Single Coverage:

Extended Health	\$105.59
Dental Single	$(\$72.96 \times 0.75)$
	\$160.31
	<u> x 2 months </u>
	\$320.62/ 10 months (Sep – Jun)
	= \$32.06 per month

Family Coverage:

Extended Health	\$242.85
Dental Family	$(\$209.89 \times 0.75)$
	\$400.27
	<u> x 2 months </u>
	\$800.54 / 10 months (Sep – Jun)
	= \$80.05 per month

10 ½ & 11 Month Employees must pay for 1 month of summer premiums:

Single Coverage:

Extended Health	\$105.59
Dental Single	$(\$72.96 \times 0.75)$
	\$160.31
	<u> x 1 month </u>
	\$160.31/ 10 months (Sep – Jun)
	= \$16.03 per month

Family Coverage:

Extended Health	\$242.85
Dental Family	$(\$209.89 \times 0.75)$
	\$400.27
	<u> x 1 month </u>
	\$400.27/ 10 months (Sep – Jun)
	= \$40.03 per month

Calculations for employees starting benefit coverage during the school year:

Employees, who start benefit coverage during the school year, will have summer premiums deducted over the remaining months until June.

Example:

10 Month Employees starting summer premium deductions in March:

$$\begin{array}{r} \text{Extended Health Family} \quad \$242.85 \\ \text{Dental Family} \quad (\$209.89 \times 0.75) \\ \hline \$400.27 \\ \times 2 \text{ months (July and Aug)} \\ \hline \$800.54 / 4 \text{ months (Mar – Jun)} \\ = \$200.14 \text{ per month} \end{array}$$

Summer premium deductions are recalculated each September to determine the cost for the following summer premiums.

To determine the cost of summer premiums, complete the following calculation entering the costs for the benefits that you will be enrolled on, using the **Monthly Premium** column as listed on the *CUPE 947 BENEFITS COSTS* sheet.

$$\begin{array}{l} \text{Extended Health (EHC)} \quad \underline{\hspace{2cm}} \\ \text{Dental} \quad \underline{\hspace{2cm}} \times 0.75 \text{ (75\% employee paid, 25\% district paid)} \\ \text{Total Monthly Premiums: } \underline{\hspace{2cm}} \text{ [add the above EHC and (Dental Premiums } \times 0.75)] \\ \text{Total Monthly Premiums } \times \underline{\hspace{1cm}} \text{ mo(s) (10 mo employees = 2 mos} \\ \hspace{15em} 10 \frac{1}{2} \text{ \& 11 mo employees = 1 mo)} \\ = \underline{\hspace{2cm}} \text{ total Summer Premiums} \\ \hspace{10em} / \underline{\hspace{1cm}} \text{ Divided by number of months until June} \\ = \underline{\hspace{2cm}} \text{ Monthly deduction until June} \end{array}$$

Please remember the calculation will depend on when your forms are received in the Payroll & Benefits Office and the Payroll deadlines.

Adjustments to Summer Premiums

Adjustments will be made throughout the school year to offset change in status, missed deductions or cancellation of coverage, premium increases (May, June). Premiums are reconciled every June to ensure that employees were deducted sufficient deductions to cover the July and August premiums. Employees who have not made sufficient deductions will be deducted the outstanding amount in June. Employees who overpaid summer premiums will be reimbursed in June. If premium increases occur after the June reconciliation, adjustments may be made in September.