NEW ENROLLMENT

BENEFITS CONTROL /WAIVER FORM – CUPE 947

You must complete and return this form together with your benefit applications.

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

Name: _____ Date: _____

Employee #: _____ School/Location: _____

Benefits applications must be submitted within 4 months of the eligibility date. Benefit coverage will start the first of the following month from the eligibility date. Benefits forms submitted after the first of the following month will be back dated and premiums will be adjusted.

If you are applying for benefit coverage for any reason other than new enrollment, please contact the Payroll & Benefits Office for the appropriate forms. If you are applying as a new enrollment but have not submitted your forms within the required deadline, please contact the Payroll & Benefits Office for late forms.

Enrollment Checklist:

Only check the boxes that apply to your situation and submit the corresponding pages:

☐ **I have read CUPE 947 BENEFITS information, FAQs, and CUPE 947 SUMMER BENEFITS**

☒ **Extended Health Care*** (Pacific Blue Cross) - **is automatically enrolled.**

☐ I wish to opt out of **Extended Health Care**

- Coverage can be waived only if the employee has other Extended Health Care coverage (by spouse or another plan). **Please complete Part 4, Waiver of Benefits, on the attached Enrollment Form**

☒ I want to enroll in Dental (Pacific Blue Cross**)**

☐ I wish to opt out of Dental (Pacific Blue Cross**)**

- Coverage can be waived only if the employee has other Extended Health Care coverage (by spouse or another plan). **Please complete Part 4, Waiver of Benefits, on the attached Enrollment Form**

X **Basic Life**** (Pacific Blue Cross) - **coverage is compulsory** and automatically enrolled

X **Basic AD&D**** (AIG Insurance Company) - **coverage is compulsory** and automatically enrolled

If you wish to enroll in additional coverage below, Optional forms available at https://www.pebt.ca/pebt-program-benefits/forms/ :

☐ Optional Life (Pacific Blue Cross) ☐ Optional AD&D (AIG Insurance Company of Canada)

Please complete pages 1, 13, and 14, (15 if applicable) before signing and returning 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.

Please see the Benefits Info and FAQ on the next pages.

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.

Greater VICTORIA School District

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:		**Family Coverage:**	
Extended Health	$105.59	Extended Health	$242.85
Dental Single	($72.96 x 0.75)	Dental Family	($209.89 x 0.75)
	$160.31		$400.27
	x 2 months		x 2 months
	$320.62/ 10 months (Sep – Jun)		$800.54 / 10 months (Sep – Jun)
	= **$32.06 per month**		= **$80.05 per month**

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

Single Coverage:		**Family Coverage:**	
Extended Health	$105.59	Extended Health	$242.85
Dental Single	($72.96 x 0.75)	Dental Family	($209.89 x 0.75)
	$160.31		$400.27
	x 1 month		x 1 month
	$160.31/ 10 months (Sep – Jun)		$400.27/ 10 months (Sep – Jun)
	= **$16.03 per month**		= $**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:

Extended Health Family $242.85
Dental Family ($209.89 x 0.75)
$400.27
x 2 months (July and Aug)
$800.54 / **4 months (Mar – Jun)**
= **$200.14 per month**

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.

Extended Health (EHC) _____

Dental _____ **x 0.75** ***(75% employee paid, 25% district paid)***

Total Monthly Premiums: _____ [*add the above EHC and (Dental Premiums x 0.75)]*

Total Monthly Premiums x ____ mo(s) (10 mo employees = 2 mos
10 ½ & 11 mo employees = 1 mo)
= _____ total Summer Premiums

/ ____ Divided by number of months until June

= _____ **Monthly deduction until June**

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.

CUPE 947 BENEFIT COSTS

Premiums are subject to carrier rate changes

July 2024

	Monthly Premium	Employee Deduction	Board Share
Premiums - September to June			
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)* *Compulsory*	.1400 per $1,000	**0%**	100%
Basic AD&D *AIG (Group # BSC 9104906)* *Compulsory*	.007 per $1,000	**0%**	100%
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.

Please complete and return the next few pages for benefit enrollment (Part 2,3,5, & 6 - Please leave Part 4 empty)

If you have other coverage and wish to waive benefits, please complete Part 2-6 and the last page waiver form.

Enrolment Form

COMPLETE THIS FORM FOR THE ADDITION OF A NEW PLAN MEMBER

This form is to be completed on the date of hire for new employees. Keep the original on file, as it will be required by the insurer if there is a a future death or disability claim.

- Section 1 to be fully completed by Plan Sponsor/Employer
- **Sections 2 - 6 to be fully completed by Plan Member/Employee**
- **Return ORIGINAL to your School District Benefits Administrator**

This Enrolment Form complies with the requirements of the Insurers for the PEBT Benefits Program and the information they require to underwrite and administer the benefits plans that are made available

○ New Applicant ○ Reinstatement

1 Plan Sponsor/Employer Information — OFFICE USE ONLY

District		District ID Number	Class	Division

Cost Centre (If applicable)	Employee Hire/Rehire Date	Employee Effective Date	ID Number
	Y Y Y Y / M M / D D	Y Y Y Y / M M / D D	

Occupation/Position	Earnings Per ___	Policy/Group Contract Numbers	Hours Worked/Week
	$		

Employment Type	Employment Status	Waiting Period (If applicable)
◉ Full-Time ○ Part-Time ○ Seasonal/Contract ○ Other:	◉ Regular ○ Temporary	

2 Plan Member/Employee Information — EMPLOYEE PLEASE COMPLETE PART 2 - 6

Last Name	First Name	Middle Initial

Marital Status

○ Single ○ Married ○ Seperated ○ Widowed ○ Divorced | Civil Union ○ Common-Law*

* Date Of Cohabitation For Common-Law: Y Y Y Y / M M / D D

Mailing Address	E-mail address	Gender
		○ M - Male ○ X - Another Gender ○ F - Female ○ U - Prefer Not to Disclose

City	Province	Postal Code	Provincial Health Plan Number (Care Card)	Date of Birth
				Y Y Y Y / M M / D D

3 Plan Member/Employee Coverage and Family Information

Please list all of your eligible dependents, even if you select single coverage

Do you have a spouse and/or dependent(s)?	Required Health Coverage	Health Effective Date
○ Yes ○ No	○ Single ○ Couple ○ Family	

Do you have a spouse and/or dependent(s)?	Required Dental Coverage	Dental Effective Date
○ Yes ○ No	○ Single ○ Couple ○ Family	

Spouse's Surname	Spouse's First Name	Spouse's Date of Birth	Gender
		Y Y Y Y / M M / D D	○ M - Male ○ X - Another Gender ○ F - Female ○ U - Prefer Not to Disclose

Does your spouse have benefits through an employer plan?	Employment Type	If yes, please provide policy #, effective date and ID:
○ Yes ○ No	○ Full-Time ○ Part-Time ○ Retiree	

Please indicate your spouse's coverage:

Health:	Dental:
○ Single ○ Couple ○ Family	○ Single ○ Couple ○ Family

Child's full name (last, first)	Date of Birth	Gender	Student **	Disabled ***
	Y Y Y Y / M M / D D	○ M - Male ○ X - Another Gender ○ F - Female ◉ U - Prefer Not to Disclose	○ Yes ○ No	○ Yes ○ No

** Provide name of school and student number of child if over 21 and studying full time

*** If child is overage and a person with a disability, state nature of disability and attach a completed PBC Disabled Dependent Application Form. Please contact your School District Benefits Administrator to confirm your district's dependent child eligibility provision.

Child's full name (last, first)	Date of Birth	Gender	Student **	Disabled ***
	Y Y Y Y / M M / D D	○ M - Male ○ X - Another ○ F - Female ◉ U - Prefer Not to Disclose	○ Yes ○ No	○ Yes ○ No

** Provide name of school and student number of child if over 21 and studying full time

*** If child is overage and a person with a disability, state nature of disability and attach a completed PBC Disabled Dependent Application Form. Please contact your School District Benefits Administrator to confirm your district's dependent child eligibility provision.

Child's full name (last, first)	Date of Birth	Gender	Student **	Disabled ***
	Y Y Y Y / M M / D D	○ M - Male ○ X - Another ○ F - Female ◉ U - Prefer Not to Disclose	○ Yes ○ No	○ Yes ○ No

** Provide name of school and student number of child if over 21 and studying full time

*** If child is overage and a person with a disability, state nature of disability and attach a completed PBC Disabled Dependent Application Form. Please contact your School District Benefits Administrator to confirm your district's dependent child eligibility provision.

To be eligible for benefits coverage, your dependent children must meet the dependent child definition outlined on the PEBT website. Disabled dependents may be eligible for benefits coverage if they became disabled before the limiting age outlined on the PEBT website and are completely dependent on you for financial support. Eligible dependents may vary depending on the benefit plan. Check with your School District Benefits Administrator for further information.

4 Waiver of Benefits

If you waive health and/or dental coverage and later lose coverage through another plan, you may apply for benefits under this plan within 31 days. Otherwise you and/or your dependents may be required to provide proof of insurability, and your benefits may be limited or denied under this plan.

If you or your dependents are presently covered for health and/or dental benefits under another benefits plan you may be able to waive coverage for such benefit(s) under this plan.

I waive coverage for myself and my dependents under :

◯ Health ◯ Dental

I waive coverage for my dependents under:

◯ Health ◯ Dental

5 Plan Member/Employee Beneficiary Information

If you designate a beneficiary who is:

(a) under 18 years of age, or
(b) mentally incapacitated

you should also designate a Trustee for that beneficiary. If this situation applies to you or you have concerns about your named beneficiary's legal status, please consult a legal advisor for further details.

Original beneficiary information will be kept by your Plan Sponsor/Employer.

Name your beneficiary(ies)

Beneficiary's Last Name		Beneficiary's First Name
Relationship to Plan Member	Percent allocated Basic/Optional Life %	Percent allocated Basic AD&D %
Beneficiary's Last Name		Beneficiary's First Name
Relationship to Plan Member	Percent allocated Basic/Optional Life %	Percent allocated Basic AD&D %
Beneficiary's Last Name		Beneficiary's First Name
Relationship to Plan Member	Percent allocated Basic/Optional Life %	Percent allocated Basic AD&D %

I appoint _____ as Trustee to receive any amount designated to a beneficiary who is under the age of 18 or mentally incapacitated.

6 Plan Member/Employee Declaration

I consent to the collection, use, and disclosure of my personal information by my Plan Sponsor/Employer or the administrator, an insurance company, or any other person or organization having any relevant information about me (collectively "the Parties") who require this information for the purpose of administering my group benefits under the plan.

I authorize the Parties to obtain and exchange between them, any personal information about me, my spouse, and my dependent children for the purpose of determining benefit entitlements, and for record keeping, file identification, reporting, underwriting, procurement of health information, claims adjudication and resolution, program management, administration of the plan and other benefits administration services provided from time to time.

Plan Member/Employee Signature _____ Date Signed (yyyy/mm/dd) _____

PLEASE RETURN PAGE 1,13, 14, (15 if applicable to you) to your SD61 Benefits Specialist using both of the methods below:

1) **email PDF to calee@sd61.bc.ca**
2) **Send ORIGINAL via mail or district mail** to your School District Benefits Administrator as it will be required by the insurer if there is a a future death or disability claim.

Waiver of Coverage

This form must be completed and signed by any employee who decides to waive Extended Health or Dental benefits because they have coverage under a spouse's plan or by any employee wishing to waive coverage while on a Leave of Absence, Maternity, Parental or EI Compassionate Care Leave. It may not be used if group insurance coverage is mandatory (e.g. where the employee does not contribute to the cost of the benefit plan), and is not required if the employee chooses not to apply for Optional Life or Optional Accident Death and Dismemberment insurance.
Please return completed form to your District Benefits Administrator.

Employee's Waiver of Rights

Employee's Last Name	First Name	Initial	District #

Covered Employee

☐ I am currently insured under the PEBT Benefits Program for my District, and

☐ My dependents and I now have coverage under another ❑ Dental ❑ Extended Health Care plan. I understand that we/I have the option of having coverage under more than one plan, but I have chosen to now waive coverage under the PEBT Benefits Program for my District for:

☐ Myself and my dependents ☐ my dependents only for ☐ Dental
☐ Myself and my dependents ☐ my dependents only for ☐ Extended Health

Termination Effective Date (yyyy/mm/dd): _____

Leave of Absence

☐ I am currently insured under the PEBT Benefits Program for my District, and

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

Please list benefit coverage to be waived:

_____

Termination Effective Date (yyyy/mm/dd): _____

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.

I hereby waive the right to the above noted benefits under the PEBT Benefits Program. I understand that proof of insurability may be required if I wish to apply for these benefits at a later date, and that I may be refused coverage at that time.

Plan Member/Employee Signature _____ Date Signed (yyyy/mm/dd) _____