Greater VICTORIA School District

ADDITION OF ELIGIBLE DEPENDENTS

BENEFITS CONTROL /WAIVER FORM - CUPE 947

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

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

Employee Name : _____ Date : _____

Employee # : _____ School/Location : _____

Eligible dependents include your spouse, unmarried over-age dependent children, or new baby. Common-law spouses are eligible after living together for a period of one year. Dependents should be added to employees' coverage within 4 months of becoming eligible dependents. If you are adding dependents after the deadline of 4 months, your dependents must apply as Late Applicants. Please contact the Payroll & Benefits Office for Late Applicant forms.

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

Please add my dependent(s) to the following benefits:

Complete included Public Education Benefits Trust Benefits Change Form:

☐ **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.

PUBLIC EDUCATION BENEFITS TRUST

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) _____

Benefits Change Form

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.

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)

○ Marriage ○ Cohabitation ○ Divorce ○ Separation ○ Death ○ Birth ○ Adoption

○ Other (specify):

Revised Extended Health Coverage	Revised Dental Coverage
○ Single ○ Couple ○ Family ○ Waived (attach Waiver of Coverage form)	○ Single ○ Couple ○ Family ○ 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.
○	○								
○	○								
○	○								
○	○								
○	○								

Part 3: Change to Spousal or Other Coverage

Change of ☐ Dental ☐ Extended Health coverage requested due to:

Date of Change (yyyy/mm/dd)

○ Spouse's plan terminated – enrol on PEBT plan (ensure Group Insurance Application is up to date or note additions on this form)

○ 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:
○ Single ○ Couple ○ Family ○ Waived (attach Waiver of Coverage form)	○ Single ○ Couple ○ Family ○ 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? ○ All applicable benefits, or: ○ Basic Life ○ Optional Life ○ Basic AD&D ○ 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**	○ Employee ○ 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)_____

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)		.1400 per $1,000	**0%**	100%
Compulsory				
Basic AD&D				
AIG (Group # BSC 9104906)		.007 per $1,000	**0%**	100%
Compulsory				
Optional Life		individual premiums	**100%**	0%
Pacific Blue Cross (Group # 53748)		see brochure for rates		
Optional AD&D		individual premiums	**100%**	0%
AIG (Group # PAI 9104940)		see brochure for rates		
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.