Greater VICTORIA School District

FINANCIAL SERVICES

556 BOLESKINE ROAD, VICTORIA, BRITISH COLUMBIA V8Z 1E8
PHONE (250) 475-4201 FAX (250) 475-6159

Payment for benefit coverage while on leave is made by Pre-Authorized Debit, as indicated in the attached documents. In addition to the benefit premiums outlined, there may be further premiums withdrawn from your account to pay for outstanding amounts due.

If you have any questions about monthly premiums while on leave, please do not hesitate to contact the Benefits Department.

Kind regards,

Caitlyn Lee

Benefits Specialist, Payroll & Benefits Office
Greater Victoria School District #61
Email: calee@sd61.bc.ca
Phone: 250-475-4201

This page is intentionally blank: Please see the FAQ and forms enclosed in this package.

PLEASE KEEP THIS INFORMATION FOR REFERENCE

Employees may continue benefit coverage while on an approved leave by paying the required benefit premiums as outlined below. The Payroll & Benefits Office will forward a *Pre-Authorized Debit (PAD) Plan Agreement* covering the cost of benefit premiums for the leave period.

Leave Type	Board contribution to premiums	Employee contribution to premiums
Maternity / Parental / Compassionate / Family Caregiver	Continued	Continued
Medical / WCB Absence Up to 6 months	Continued	Continued
Medical / WCB Absence After 6 months	-	Continued at 100% of cost
Parenthood / Personal / Educational/ LTD > 2 Yrs	-	Continued at 100% of cost

Continuation of coverage

If you would like to continue coverage for the period of your approved leave, please indicate on your notice that you wish to continue all coverage and return with an authorized PAD Plan Agreement to the Payroll & Benefits Office within 30 days. Please ensure that you sign and date your notice.

Cancellation or suspension of benefits

If you do not wish to continue benefit coverage, please indicate on your notice that you do not wish to continue coverage and return to the Payroll & Benefits Office. Please ensure that you sign and date the cancellation.

You may choose to participate in selected coverage. If you do not wish to continue all coverage during your leave, please indicate the benefits you do not wish to continue, authorize the notice, and submit your PAD Plan Agreement for the benefits you wish to continue.

Long-term Disability coverage will terminate 31 days after the start of a Parenthood, Personal or Educational leave.

Cancellation due to unauthorized PAD Plan Agreements

Please note that it is important that your PAD Plan Agreement be received by the School District within 30 days of the invoice date. Failure to meet this deadline will result in termination of benefit coverage.

Re-instatement of benefit coverage upon return to work

To re-instate benefit coverage upon return to work, employees must re-apply for coverage within carrier deadlines. Employees must be eligible and complete applications within 30 days of their return to work date. If an employee is eligible when returning to work and does not reapply within 30 days, coverage may be denied. **Coverage cannot be re-instated while on leave.**

For further information on benefit coverage on leave please visit www.pebt.ca

CUPE 382 BENEFIT COSTS

Premiums are subject to carrier rate changes

July 2024

		Monthly Premium	Employee Deduction	Board's Share
Pacific Blue Cross (Group # 53724)				
Extended Health	Single	90.91	**0%**	90.91 (100%)
	Couple	163.64	**0%**	163.64 (100%)
	Family	209.09	**0%**	209.09 (100%)
Pacific Blue Cross (Group # 53724)				
Dental	Single	71.36	**17.84 (25%)**	53.52 (75%)
	Couple	140.71	**35.18 (25%)**	105.53 (75%)
	Family	205.23	**51.31 (25%)**	153.92 (75%)
Pacific Blue Cross (Group # 053724) Compulsory				
Basic Life		.1400 per $1,000	**0%**	100%
AIG (Group # BSC 9104906) Compulsory				
Basic AD&D		.0070 per $1,000	**0%**	100%
Pacific Blue Cross (Group # 053724)				
Optional Life		individual premiums see brochure for rates	**100%**	0%
AIG (Group # PAI 9104940)				
Optional AD&D		individual premiums see brochure for rates	**100%**	0%

*on a PLOA, or Educ Leave, or Parenthood Leave, or LTD > 2 years, or UnPd Medical Lv > 6 months: Benefit Premiums are 100% employee paid (Monthlly Premium Column)

CUPE 382 Benefit Deduction Calendar 2024-2025

Friday, July 26, 2024

Friday, August 23, 2024

Friday, September 20, 2024

Friday, October 18, 2024

Friday, November 15, 2024

Friday, December 13, 2024

Friday, January 24, 2025

Friday, February 21, 2025

Friday, March 21, 2025

Thursday, April 17, 2025

Friday, May 16, 2025

Friday, June 27, 2025

Please return completed form to your District Benefits Administrator.

Public Education PEBT BENEFITS TRUST
Your benefits, your health

Notice of Leave

Employee Information

Plan Member/Employee's Last Name	First Name	Initial	District #:
			Claims ID #:

Leave of Absence from: _____ to: _____
(yyyy/mm/dd) (yyyy/mm/dd)

Reason for Leave: _____

Do you plan to leave the province during your leave? ☐ No ☐ Yes from:_____ to:_____
If Yes, Destination: _____ (yyyy/mm/dd) (yyyy/mm/dd)

Use back of form if information about destination and dates do not fit in space provided. If yes, please note that your Provincial Health plan must approve continuation of coverage for a leave of absence outside of the province exceeding 6 months. Coverage for Extended Health ceases the day you are no longer covered under your Provincial Health plan.

Please indicate the benefits to be continued during your leave of absence and the current level of coverage:

Current level of coverage

- ☐ Basic Life Insurance _____
- ☐ Optional Life Insurance (if applicable) □ Employee: _____ □ Spouse: _____ □ Child: _____
- ☐ Basic Accident Insurance (if applicable) _____
- ☐ Optional Accident Insurance (if applicable) _____
- ☐ Extended Health (please circle): ☐ Single ☐ Couple ☐ Family
- ☐ Dental Care (please circle): ☐ Single ☐ Couple ☐ Family
- ☐ Short Term Disability (if applicable) _____
- ☐ Long Term Disability _____

Please note that long term disability (LTD) can be continued through Maternity, Parental and EI Compassionate leave as well as for an employee who is seconded, elected, on paid leave of absence, appointed to Union positions or is elected/appointed to public office. LTD cannot be continued for any other unpaid leave of absence over 31 days. Following an unpaid leave of absence of more than 31 days, your LTD coverage will be reinstated only after you return to work, and complete the waiting period of 3 consecutive months of active employment.

Benefits will continue through Maternity Leave, Parental Leave and EI Compassionate Care Leave. However, should you not wish to continue to pay your share of premium contribution for benefits during these leave of absences, your District is not required to pay your portion of the premium and continue coverage on your behalf. Please check with your Benefits Administrator regarding continuation of coverage policies specific to your District in these circumstances. For any benefits shown above that you have chosen not to continue, you are waiving your rights to these benefits until you return from your leave of absence. If you are eligible to continue the Other LTD (top up to the Core LTD) coverage but choose not to, any disability that occurs during your leave of absence will not be covered by the PEBT Other LTD Program.

Please note that cost sharing arrangements may be different while on a leave of absence for leaves other than Maternity, Parental and EI Compassionate leave. Please check with your District Benefits Administrator for cost sharing information.

Your District Benefits Administrator will inform you how long coverage for each benefit will be continued while you are on a leave of absence.

I certify that I understand the above and have been informed by the District's Benefits Administrator of the coverage available to me during my leave of absence.

Plan Member/Employee Signature: _____ Date Signed: _____

Benefits Administrator, please email to PBC at enrollment@pac.bluecross.ca

Please complete ·Pre-Authorized Debit (PAD) Plan Agreement Below

1/We authorize THE BOARD OF EDUCATION SCHOOL DISTRICT 61 (GREATER VICTORIA), and the financial institution designated (or any other financial institution 1/we may authorize at any time) to begin deductions as per my/our instructions for regular monthly recurring payments and/or one-time payments from time to time, for payment of all charges arising under my/our THE BOARD OF EDUCATION SCHOOL DISTRICT 61 (GREATER VICTORIA) Regular payments for the full amount of services delivered will be debited to my/our specified account on the last debit date of each month (see attached schedule). THE BOARD OF EDUCATION SCHOOL DISTRICT 61 (GREATER VICTORIA) will provide 10 days written notice of the amount of each regular debit. THE BOARD OF EDUCATION SCHOOL DISTRICT 61 (GREATER VICTORIA) will obtain my/our authorization for any other one-time or sporadic debits.

This authority is to remain in effect until THE BOARD OF EDUCATION SCHOOL DISTRICT 61 (GREATER VICTORIA) has received written notification from me/us of its change or termination. This notification must be received at least (10) ten business days before the next debit is scheduled at the address provided below. 1/We may obtain a sample cancellation form, or more information on my/our right to cancel a PAD Agreement at my/our financial institution or by visiting www.cdnpay.ca.

THE BOARD OF EDUCATION SCHOOL DISTRICT 61 (GREATER VICTORIA) may not assign this authorization, whether directly or indirectly, by operation of law, change of control or otherwise, without providing at least 10 days prior written notice to me/us.

1/We has certain recourse rights if any debit does not comply with this agreement. For example, 1/we have the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. To obtain a form for a Reimbursement Claim, or for more information on my/our recourse rights, 1/we may contact my/our financial institution or visit www.cdnpay.ca.

Type of Service: Personal

PLEASE PRINT **DATE:**_____

Name: _____

Address: _____

City/Town:_____ Province:_____ Postal Code:_____

Phone Number (Bus):_____ (Res):_____

Financial Institution {FI):____AS ON FILE IN THE SCHOOL DISTRICT PAYROLL SYSTEM_____

Fl Account Number: N/A_____ Fl Transit Number: N/A_____

Address:_____N/A_____ _____

City/Town:_____N/A_____ Province:_____N/A_____ Postal Code:_____N/A_____

Authorized Signature(s):._____

The Board of Education School District 61 (Greater Victoria)

For all benefit inquiries, please contact Caitlyn Lee at the Payroll & Benefits

Office: calee@sd61.bc.ca or (250) 475-4201.

EMPLOYEE BENEFIT CANCELLATION

Employee Name: _____

Employee Number: _____

Employee Group:

Teacher ☐ Allied Specialists ☐ Principals & Vice Principals ☐

Exempt ☐ CUPE 947 ☐ CUPE 382 ☐

Teacher (TTOC) ☐

Please cancel the following benefit coverage:

☐ Extended Health (CUPE employees must complete PEBT Waiver of Coverage Form)

☐ Dental (only district benefit for TTOC)

☐ Basic Life (coverage is compulsory for CUPE, Exempt & PVP)

☐ Basic AD&D (coverage is compulsory for CUPE)

☐ Optional Life

☐ Optional AD&D

Requested Date of Cancellation: _____

The cancellation date is always the last day of a current month

Reason for Cancellation: _____

Signature: _____ Date: _____

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) _____