Greater VICTORIA School District

ADDITION OF ELIGIBLE DEPENDENTS

BENEFITS CONTROL /WAIVER FORM - CUPE 382

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, and unmarried, dependent children. 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)

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

Please return completed form to your District Benefits Administrator.

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)_____

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)