EMPLOYEE ENROLMENT DUE TO CANCELLATION OF OTHER COVERAGE

BENEFITS CONTROL /WAIVER FORM – CUPE 382

You must complete and return this form together with the Enrolment Form

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.

Employee Name : _____ Date : _____

Employee # : _____ School/Location : _____

Applications must be received in the Payroll & Benefits Office within 31 days of the loss of other benefit coverage.

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

Benefits required:

Complete Public Education Benefits Trust Benefits Enrolment 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.

TRANSFER FORM

EXTENDED HEALTH AND DENTAL COVERAGE DUE TO CANCELLATION OF OTHER COVERAGE

EMPLOYEE ENROLMENT

Employees terminating from spousal or other coverage can apply to transfer from their other coverage to the District plans. The transfer must be done at the time of cancellation. Example: Spousal or other coverage terminates March 31st - employees must apply for coverage April 1st.

Employees must supply written proof of cancellation from the plan the employee is terminating from by having the Plan Administrator complete and sign this form, or supply written information which includes all the information below.

School district employee name & employee number:

_____

Name of Benefit Holder of terminating plan: _____

Name of persons terminating from plan: _____

EXTENDED HEALTH

Carrier name & contact phone # _____

Plan group #: _____

ID #: _____

Termination date: _____

DENTAL

Carrier name & contact phone # _____

Plan group #: _____

ID #: _____

Termination date: _____

Name of Employer or Plan Holder: _____

Signature of Plan Administrator: _____ Date: _____

This information will be verified by the Payroll & Benefits Office and the Benefits Carrier. Coverage through the school district cannot be set up until the other coverage is cancelled. Forms should not be sent to the Payroll & Benefits Office until close to the cancellation date. The forms will be returned to the employees if the information is incomplete, incorrect or if the other coverage is not cancelled.

Employees who do not apply for transfer of coverage within carrier deadlines, may apply by completing Late Applicant forms. Please contact the Payroll & Benefits Office for these.

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 Pages 1- 4 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.

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)

C U P E 3 8 2 B E N E F I T S

PLEASE KEEP THIS INFORMATION FOR REFERENCE

For benefit information, please visit the following website:

Public Education Benefit Trust (PEBT) 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 first of the following month from employees' benefit eligibility date.

Benefit eligibility:

- 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 Care or Dental coverage cancels e.g. spousal coverage

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. Employees who do not enrol on Dental when eligible, may not qualify at a later date.

CUPE 382 BENEFIT FAQS

WAIVING EXTENDED HEALTH CARE COVERAGE

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

WAIVING DENTAL COVERAGE

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

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 insurance carrier for review. If additional information is required, the insurance carrier will contact the employee directly.

EXTENDED HEALTH CARE, 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 or on the website @ www.pebt.ca.

CUPE 382 BENEFIT FAQS

WHAT IS MY BENEFIT ELIGIBILITY DATE?

- 90 working days from the start of a regular assignment and in an assignment of 20 hours or more per week (spare board time worked may apply)
- 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 382 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 382 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