

# LATE ENROLLMENT

## BENEFITS CONTROL / WAIVER FORM – CUPE 382

*You must complete and return this form together with the Enrolment Form and Statement of Health*

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.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Employee #: \_\_\_\_\_ School/Location: \_\_\_\_\_

If you are applying for benefit coverage for any reason other than LATE enrollment, please contact the Payroll & Benefits Office for the appropriate forms.

**Late applications will be forwarded to Pacific Blue Cross for review. Pacific Blue Cross will determine if you will be approved for coverage. If approved, they will determine the effective date of coverage.**

**Benefits required:**

**Complete** Public Education Benefits Trust Benefits Enrolment form and Statement of Health:

\_\_\_\_\_ **Extended Health** (Pacific Blue Cross)

\_\_\_\_\_ **Dental** (Pacific Blue Cross)

Basic Life and Basic AD&D coverage are mandatory and automatically set up for eligible employees

**Optional forms available on [www.pebt.ca](http://www.pebt.ca):**

\_\_\_\_\_ **Optional Life** (Pacific Blue Cross)

\_\_\_\_\_ **Optional AD&D** (AIG)

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 complete and  
return the forms  
following this page.**



**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) \_\_\_\_\_

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.

# Benefits Change Form

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)	
<input type="radio"/> Marriage <input type="radio"/> Cohabitation <input type="radio"/> Divorce <input type="radio"/> Separation <input type="radio"/> Death <input type="radio"/> Birth <input type="radio"/> Adoption									
<input type="radio"/> Other (specify):									
Revised Extended Health Coverage					Revised Dental Coverage				
<input type="radio"/> Single <input type="radio"/> Couple <input type="radio"/> Family <input type="radio"/> Waived (attach Waiver of Coverage form)					<input type="radio"/> Single <input type="radio"/> Couple <input type="radio"/> Family <input type="radio"/> 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.
<input type="radio"/>	<input type="radio"/>								
<input type="radio"/>	<input type="radio"/>								
<input type="radio"/>	<input type="radio"/>								
<input type="radio"/>	<input type="radio"/>								
<input type="radio"/>	<input type="radio"/>								
Part 3: Change to Spousal or Other Coverage									
Change of <input type="radio"/> Dental <input type="radio"/> Extended Health coverage requested due to:								Date of Change (yyyy/mm/dd)	
<input type="radio"/> Spouse's plan terminated – enrol on PEBT plan (ensure Group Insurance Application is up to date or note additions on this form)									
<input type="radio"/> 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:				
<input type="radio"/> Single <input type="radio"/> Couple <input type="radio"/> Family <input type="radio"/> Waived (attach Waiver of Coverage form)					<input type="radio"/> Single <input type="radio"/> Couple <input type="radio"/> Family <input type="radio"/> 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? <input type="radio"/> All applicable benefits, or: <input type="radio"/> Basic Life <input type="radio"/> Optional Life <input type="radio"/> Basic AD&D <input type="radio"/> 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	<input type="radio"/> Employee <input type="radio"/> 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) \_\_\_\_\_

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | 604 419-2000 or Toll Free 1 877 PAC-BLUE | Fax: 604 419-2149

**i APPLICANTS — Please complete PART 2-7 of this application and return to [enrollment@pac.bluecross.ca](mailto:enrollment@pac.bluecross.ca).**  
**If applying for Optional Life coverage, please also complete a Beneficiary Designation form.**  
**EMPLOYERS/PLAN ADMINISTRATORS — Please complete PART 1 of this application.**

**PART 1 — EMPLOYER/PLAN ADMINISTRATOR**

Policy number	Name of company/organization	Member ID number	Date of hire/rehire (mm-dd-yyyy)
Reason for application <input type="checkbox"/> Late enrollment <input type="checkbox"/> Increase coverage <input type="checkbox"/> Annual re-enrollment		Who is this application for <input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent(s)	
Type of insurance and amount applying for			
<input type="checkbox"/> Life/Accidental death & dismemberment \$ _____	<input type="checkbox"/> Short-term disability \$ _____	<input type="checkbox"/> Member Optional Life \$ _____	
<input type="checkbox"/> Dependent life \$ _____	<input type="checkbox"/> Long-term disability \$ _____	<input type="checkbox"/> Spouse Optional Life \$ _____	
<input type="checkbox"/> Extended health care	<input type="checkbox"/> Critical illness \$ _____	<input type="checkbox"/> Member Optional Critical Illness \$ _____	
<input type="checkbox"/> Dental		<input type="checkbox"/> Spouse Optional Critical Illness \$ _____	

**PART 2 — APPLICANT INFORMATION**

Legal first name	Middle initial	Last name	Birthdate (mm-dd-yyyy)	Gender* <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> U <input type="checkbox"/> X
Country of birth	Occupation	Height	Weight	
Address		City	Province	Postal code
Email		Phone number	Fax	

**Physician and medical records**

Please select one of the following and complete the details below accordingly  
☐ Below is my primary physician's information ☐ I don't have a primary physician, but the clinic below has my records

Physician's first name	Physician's last name	Clinic name		
Address		City	Province	Postal code
Email		Phone number	Fax	

**PART 3 — ADDITIONAL INDIVIDUALS TO BE COVERED**

Only fill out part 3 if there are additional individuals that you are applying for.

**Spousal information**

Legal first name	Middle initial	Last name	Birthdate (mm-dd-yyyy)	Height	Weight
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**Dependent(s) information****Dependent 1**

Legal first name	Middle initial	Last name	Birthdate (mm-dd-yyyy)	Gender* <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> U <input type="checkbox"/> X
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**Dependent 2**

Legal first name	Middle initial	Last name	Birthdate (mm-dd-yyyy)	Gender* <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> U <input type="checkbox"/> X
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**Dependent 3**

Legal first name	Middle initial	Last name	Birthdate (mm-dd-yyyy)	Gender* <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> U <input type="checkbox"/> X
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**Dependent 4**

Legal first name	Middle initial	Last name	Birthdate (mm-dd-yyyy)	Gender* <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> U <input type="checkbox"/> X
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\*F = Female, M = Male, U = Prefer not to disclose, X = Another gender

## PART 4 — GENERAL DECLARATION

		MEMBER	SPOUSE
1. Have you or your spouse used any form of tobacco, tobacco cessation products, nicotine, e-cigarettes, or nicotine replacement products in the last 12 months? If yes, provide details (Member) _____ If yes, provide details (Spouse) _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has your weight decreased more than 4.5 kg or 10 lbs in the past year?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Member	If yes, how much weight was lost? _____ Reason(s) for weight loss _____		
Spouse	If yes, how much weight was lost? _____ Reason(s) for weight loss _____		
3. Have you or your dependents ever applied for or received benefits, compensation, or pension due to injury or disability? If yes, provide details. If yes, provide details (Member) _____ If yes, provide details (Spouse) _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Dependents</b> Fill this out if this applies to 1 or more of your dependents. You do not need to identify which dependent. <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide details _____			

## PART 5 — MEDICAL DECLARATION

5.1 Have you, your spouse or dependent(s) consulted a physician, been treated for or have/had any known indication of any of the following medical conditions? If you are unsure how to answer any of these questions, please consult your doctor.

If you answer yes to any section in question 5.1 and/or 5.2, please complete question 5.4.

	MEMBER (YOU)	SPOUSE	DEPENDENT(S)
a) <b>Cardiovascular or circulatory</b> including vascular disease, high blood pressure, elevated cholesterol, heart attack, angina, stroke or TIA (mini-stroke) and blood disorders.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) <b>Diabetes / Endocrine disorders</b> including Type 1 or Type 2, hormonal or thyroid conditions.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) <b>Gastrointestinal conditions</b> including stomach, intestinal or liver conditions (including hepatitis A, B, C or B carrier state), Colitis, Crohn's disease, Irritable Bowel Syndrome, Diverticulitis, Colon polyps, Ulcers, Hernia, GERD (acid reflux or persistent heartburn).	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) <b>Respiratory or Lung conditions</b> including Allergies, Asthma, Bronchitis, Chronic Obstructive Pulmonary Disease (COPD), Sleep Apnea.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) <b>Musculoskeletal conditions</b> including Osteoarthritis or Rheumatoid Arthritis, Osteoporosis, bone density loss or back, neck, limb or joint pain (including Fibromyalgia).	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) <b>Immunological conditions</b> including being tested for, counselled for, treated for or told you have AIDS (Acquired Immune Deficiency Syndrome), HIV (Human Immunodeficiency Virus) or any other immunological disorder.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g) <b>Genitourinary conditions</b> including kidney, bladder, infertility or Reproductive Disorders, Menopause, Endometriosis, Sexually Transmitted Disease(s) or recurring infections (cold sore/ Herpes/Shingles).	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h) <b>Neurological conditions</b> including Alzheimer's, Dementia, Parkinson's, epilepsy, Multiple Sclerosis, Seizures, Paralysis, chronic headaches or migraines, or Chronic Fatigue Syndrome.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i) <b>Mental or Nervous conditions</b> including Anxiety, Depression, Emotional Disorders, Eating Disorders, Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD).	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j) <b>Cancer and Tumors</b> including malignant or benign, leukemia.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
k) <b>Drugs</b> including ever used narcotics, stimulants, hallucinogens or other drugs except those that were prescribed by a physician.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

## PART 5 — MEDICAL DECLARATION (continued)

	MEMBER (YOU)	SPOUSE	DEPENDENT(S)
5.2 Within the past five years, have you had any medical conditions not already mentioned on this form or abnormal test results?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.3 Do you currently have a referral, testing, treatment or investigation pending or contemplated but not yet completed, or are you aware of any symptoms or problems that require medical attention? If yes, provide details _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.4 If you answered YES to any part of question 5.1 and/or 5.2, please provide details. Please use one section per condition/disorder, even if an individual has multiple conditions/ disorders.			

Name of individual	Diagnosis date (mm-dd-yyyy)	<input type="checkbox"/> Same physician as in part 2.3	
Condition/disorder	Physician name		
Medication/treatment	Address		
Recovery date (mm-dd-yyyy)	Email	Phone number	
Name of individual	Diagnosis date (mm-dd-yyyy)	<input type="checkbox"/> Same physician as in part 2.3	
Condition/disorder	Physician name		
Medication/treatment	Address		
Recovery date (mm-dd-yyyy)	Email	Phone number	
Name of individual	Diagnosis date (mm-dd-yyyy)	<input type="checkbox"/> Same physician as in part 2.3	
Condition/disorder	Physician name		
Medication/treatment	Address		
Recovery date (mm-dd-yyyy)	Email	Phone number	

If there aren't enough sections in 5.4, please add details to the box below. Include the name of the individual (i.e., your name, spouse, or a dependent), conditions/disorders, diagnosis date, medication/treatment, and physician information.

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5.5 Are you, your spouse or dependents taking any other prescribed medication(s) that you have NOT already disclosed above? If yes, provide name of medication(s) and reason below. Please use one section per individual, even if the individual is using multiple medications.

Name of individual	Medication(s)
Dosage	Frequency
Reason(s) for medication	
Name of individual	Medication(s)
Dosage	Frequency
Reason(s) for medication	
Name of individual	Medication(s)
Dosage	Frequency
Reason(s) for medication	

## PART 5 — MEDICAL DECLARATION (continued)

If there aren't enough sections in 5.5, please add details to the box below. Include the name of the individual (i.e., your name, spouse, or a dependent), name of medication(s), dosage, frequency and reason(s) for medication.

5.6 Please identify any biological parents or siblings of yourself and/or your spouse who before the age 60, have ever had cancer, heart or kidney disease, mental or nervous disorder or any inheritable disorder (such as Huntington's chorea or polycystic kidney disease).

INDIVIDUAL	DETAILS OF THE CONDITION
Member's parent 1	
Member's parent 2	
Member's sibling	
Member's sibling	
Spouse's parent 1	
Spouse's parent 2	
Spouse's sibling	
Spouse's sibling	

## PART 6 — DECLARATION AND AUTHORIZATION

I, the undersigned, declare that the answers to the above questions and the questions on the reverse of this form are complete and accurate and form part of an application for coverage with Blue Cross Life Insurance Company of Canada (Blue Cross Life) and/or Pacific Blue Cross. The information provided herein and collected in the future as part of the application process will be kept confidential and secure. This information will be used to determine eligibility for coverage, to administer the terms of my policy, to recommend suitable products and services to me and to manage the company's business. For these purposes, I (i) authorize any physician, health practitioner, hospital, clinic, pharmacy, or other medical or medically related facility, insurance company, government or regulatory authority, the MIB, LLC, or other organization, institute or person, that has any records or knowledge of me/my child or my/their health, to give Blue Cross Life, Pacific Blue Cross or their reinsurer any such information and (ii) Blue Cross Life and Pacific Blue Cross to access and use relevant information in records that they already hold about me.

I further authorize Blue Cross Life and Pacific Blue Cross to disclose this information to each other, their reinsurer or to any third party when required to determine eligibility of the application. Medical information may also be released to my/my child's personal physician or other medical practitioner. I have received and read the enclosed notice form describing the procedures of the MIB, LLC. I authorize Blue Cross Life and/or Pacific Blue Cross, or its reinsurer, to make a brief report of my personal health information to the MIB, LLC.

This consent is valid for as long as the contract is in force unless I revoke it in writing. I understand I may revoke my consent at any time; however, if consent is withheld or revoked the coverage may be denied or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent. If I have questions about the collection, use or disclosure of my or my dependent's personal information, I can visit <https://www.pac.bluecross.ca/privacy>. A photocopy of this authorization shall be as valid as the original.

Member signature <b>X</b>	Date (mm-dd-yyyy)
Spouse signature <b>X</b>	Date (mm-dd-yyyy)

## PART 7 — MIB, LLC PRE-NOTICE

### ⚠ IMPORTANT: Please read carefully.

Information regarding your insurability will be treated as confidential. Blue Cross Life Insurance Company of Canada or its reinsurers may, however, make a brief report thereon to MIB, LLC. which operates an information exchange on behalf of insurance companies that are members of MIB Group Inc. If you apply to another MIB, LLC member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, LLC, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the MIB, LLC. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB, LLC's files, you may contact the MIB, LLC and seek a correction. The address of the MIB LLC's information office is: MIB, LLC 50 Braintree Hill Park, Suite 400 Braintree, MA 02184-8734. Telephone: 1 866 692-6901. [www.mib.com](http://www.mib.com)

Blue Cross Life Insurance Company of Canada or their reinsurer may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.







## CUPE 382 BENEFIT COSTS

Premiums are subject to carrier rate changes

July 2024

		<u>Monthly Premium</u>	<u>Employee Deduction</u>	<u>Board's Share</u>
<i>Pacific Blue Cross (Group # 53724)</i>				
<b>Extended Health</b>	Single	90.91	0%	90.91 (100%)
	Couple	163.64	0%	163.64 (100%)
	Family	209.09	0%	209.09 (100%)
<i>Pacific Blue Cross (Group # 53724)</i>				
<b>Dental</b>	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%)
<i>Pacific Blue Cross (Group # 053724) Compulsory</i>				
<b>Basic Life</b>	.1400 per \$1,000		0%	100%
<i>AIG (Group # BSC 9104906) Compulsory</i>				
<b>Basic AD&amp;D</b>	.0070 per \$1,000		0%	100%
<i>Pacific Blue Cross (Group # 053724)</i>				
<b>Optional Life</b>	individual premiums see brochure for rates		100%	0%
<i>AIG (Group # PAI 9104940)</i>				
<b>Optional AD&amp;D</b>	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 (Monthly 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](http://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](http://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](http://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.



## 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.

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