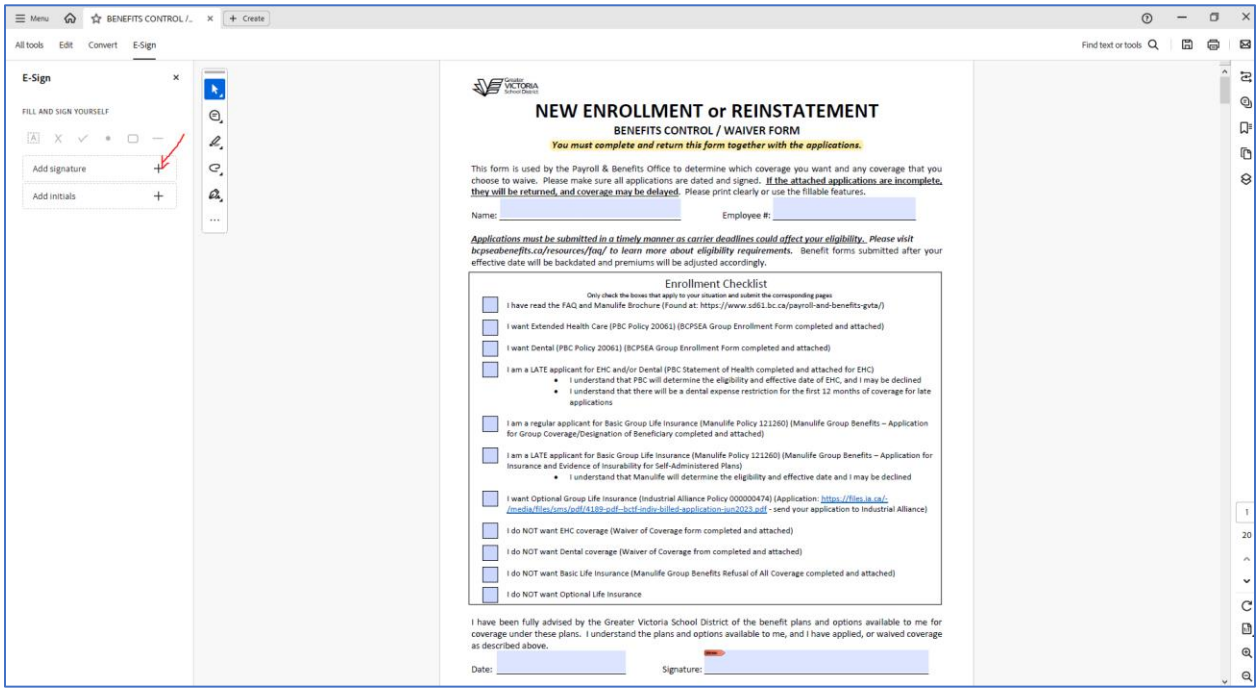
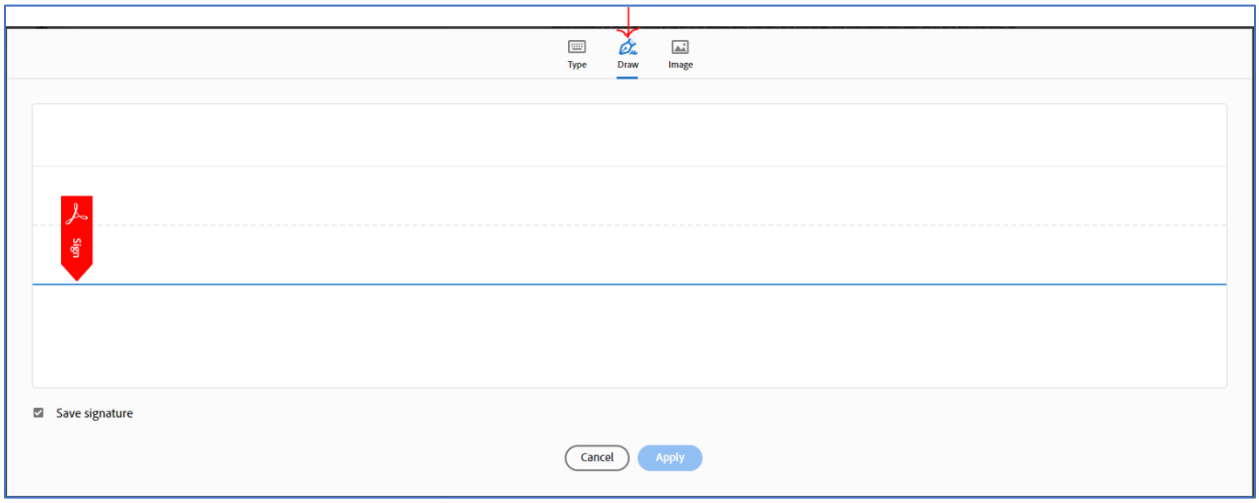
How to fill in and submit your benefits forms in 11 steps (late applicant):

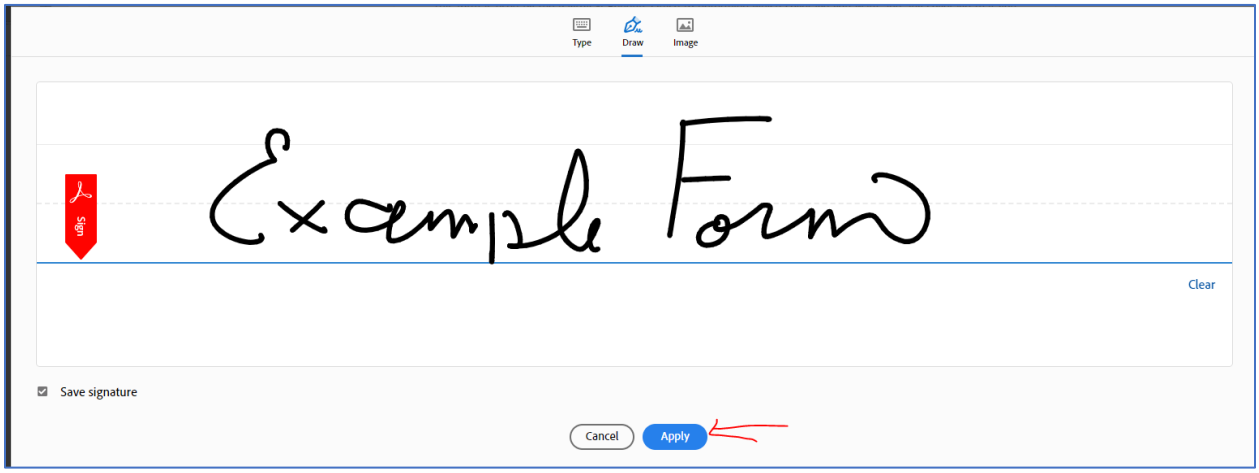
1) Download and read the FAQ from the website: https://www.sd61.bc.ca/payroll-and-benefits-gvta/.
2) Download and read through the New Enrollment or Reinstatement application package.
3) Open the blank form with Adobe.
4) Create a signature in Adobe.
    a. Select E-sign; Add signature.



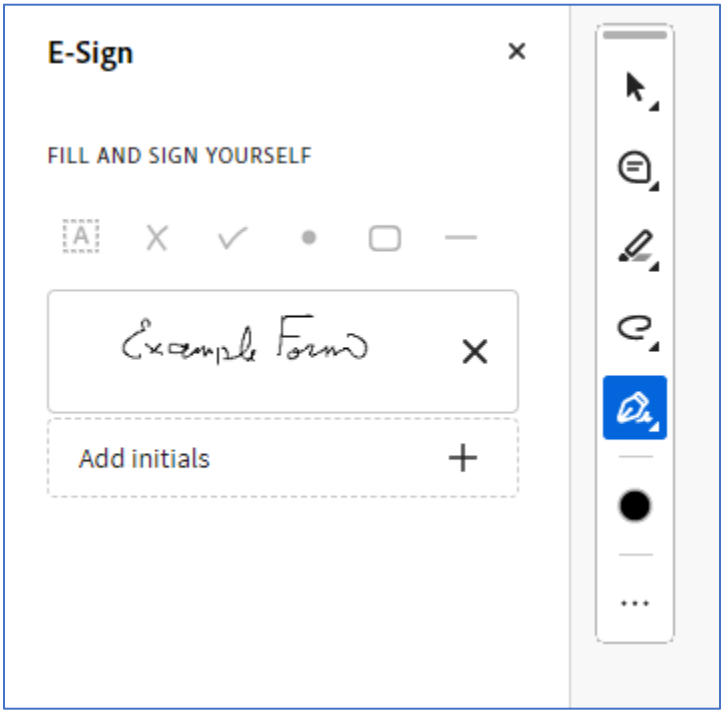
    b. Select Draw.



c. Use your mouse, or finger, to draw your signature and select Apply.

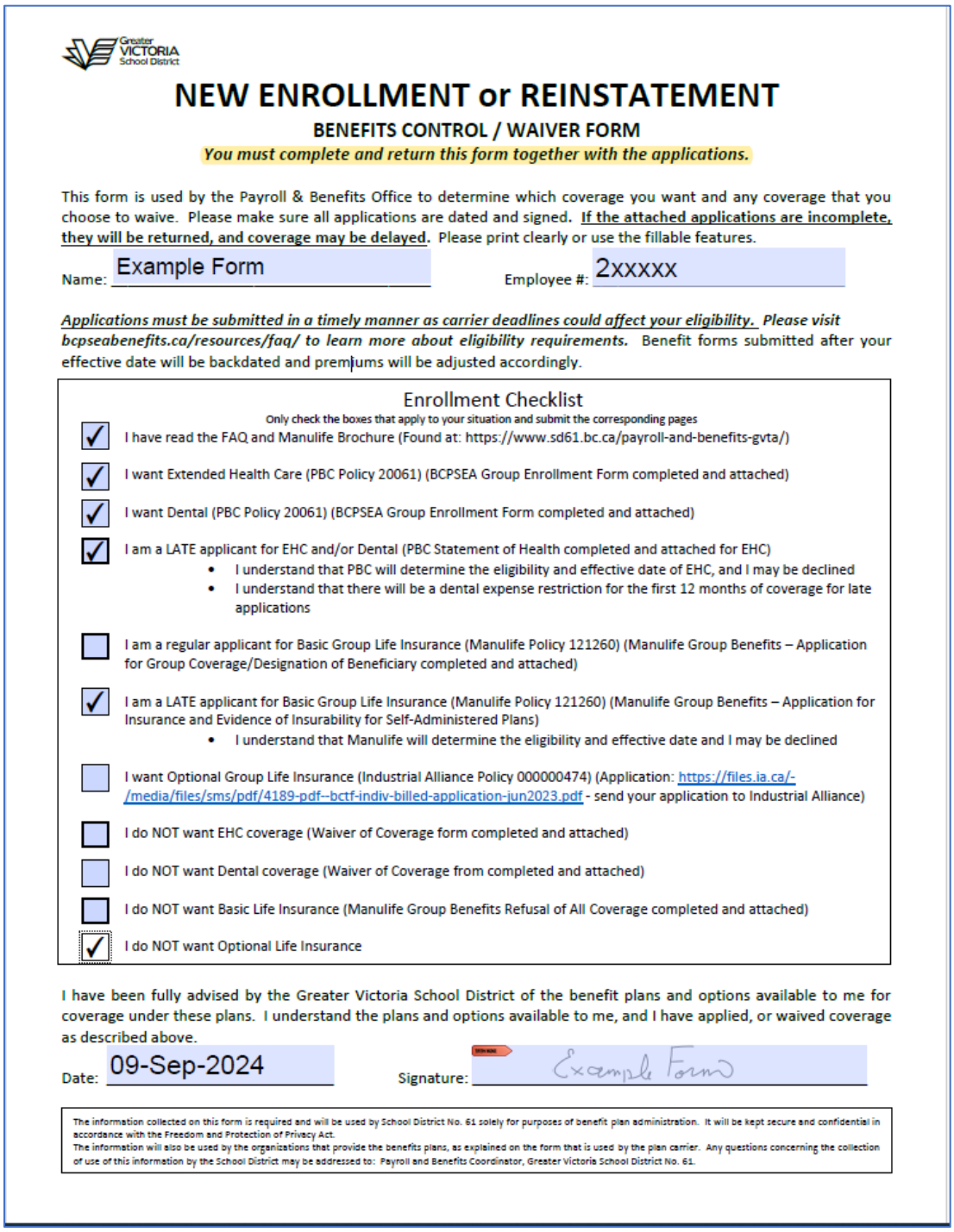


d. Your signature is now saved for use when you select the Fill and Sign option.



e. If you cannot sign with a drawn digital signature, please print your completed forms and sign in ink before scanning them to yourself and then emailing to benefits@sd61.bc.ca.

5) After you have read and understood the FAQ and Manulife brochure, complete the cover sheet:
   a. Add you name and employee number.
   b. Select the benefits you want or do not want.
   c. Date and sign the form – with the signature you created or print and sign in ink.



Greater VICTORIA School District

NEW ENROLLMENT or REINSTATEMENT

BENEFITS CONTROL / WAIVER FORM

You must complete and return this form together with the applications.

This form is used by the Payroll & Benefits Office to determine which coverage you want and any coverage that you choose to waive. 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 or use the fillable features.

Name: Example Form Employee #: 2xxxxx

Applications must be submitted in a timely manner as carrier deadlines could affect your eligibility. Please visit bcpseabenefits.ca/resources/faq/ to learn more about eligibility requirements. Benefit forms submitted after your effective date will be backdated and premiums will be adjusted accordingly.

Enrollment Checklist

Only check the boxes that apply to your situation and submit the corresponding pages

- [x] I have read the FAQ and Manulife Brochure (Found at: https://www.sd61.bc.ca/payroll-and-benefits-gvta/)
- [x] I want Extended Health Care (PBC Policy 20061) (BCPSEA Group Enrollment Form completed and attached)
- [x] I want Dental (PBC Policy 20061) (BCPSEA Group Enrollment Form completed and attached)
- [x] I am a LATE applicant for EHC and/or Dental (PBC Statement of Health completed and attached for EHC)
  - I understand that PBC will determine the eligibility and effective date of EHC, and I may be declined
  - I understand that there will be a dental expense restriction for the first 12 months of coverage for late applications
- [ ] I am a regular applicant for Basic Group Life Insurance (Manulife Policy 121260) (Manulife Group Benefits – Application for Group Coverage/Designation of Beneficiary completed and attached)
- [x] I am a LATE applicant for Basic Group Life Insurance (Manulife Policy 121260) (Manulife Group Benefits – Application for Insurance and Evidence of Insurability for Self-Administered Plans)
  - I understand that Manulife will determine the eligibility and effective date and I may be declined
- [ ] I want Optional Group Life Insurance (Industrial Alliance Policy 000000474) (Application: https://files.ia.ca/-/media/files/sms/pdf/4189-pdf--bctf-indiv-billed-application-jun2023.pdf - send your application to Industrial Alliance)
- [ ] I do NOT want EHC coverage (Waiver of Coverage form completed and attached)
- [ ] I do NOT want Dental coverage (Waiver of Coverage from completed and attached)
- [ ] I do NOT want Basic Life Insurance (Manulife Group Benefits Refusal of All Coverage completed and attached)
- [x] I do NOT want Optional Life Insurance

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: 09-Sep-2024 Signature: Example Form

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 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 of use of this information by the School District may be addressed to: Payroll and Benefits Coordinator, Greater Victoria School District No. 61.

6) Complete the Group Enrollment Form for extended health and dental (2 pages)

You MUST complete this form.

BRITISH COLUMBIA PUBLIC SCHOOL EMPLOYERS' ASSOCIATION
SOLUTIONS AT WORK

The Group Enrolment Form complies with the requirements of the Insurers for the BCPSEA Benefits Buying Group Program and the information they require to underwrite and administer the benefit plans that are made available

Please return form to your District Benefits Administrator.
Administrators: This form is to be completed on the date of hire for new employees. Keep the original copy on file, as it will be required by the insurer if there is a future death or disability claim.

Group Enrolment Form

☑ New applicant ☐ Reinstatement ☑ Late applicant

Part 1: Employee and Basic Insurance Information

Employee's Last Name	First Name	Initial	ID Number[1]	Provincial Health Plan Number (Care Card)
Form,	Example	T	2xxxxx	

Street Address	E-mail Address	Birthdate (MM/DD/YY)	Sex	Family Status
123Fake St.	eform@fake.email	01/02/1934	☐ M ☑ F	☐ Single ☐ Couple ☑ Family

City	Province	Postal Code
Victoria	BC	V#X #X#

If Extended Health or Dental benefits are Waived, complete this form and attach a Refusal of Coverage form

Dependents (Spouse and/or Children)

First Name	Initial	Last Name (if different from Employee)	Birthdate (MM/DD/YY)	Relationship (Married, Common-Law, Child - minor or student)	Sex (M/F)	Required coverage (Complete Waiver if either is not needed)	Provide name of school and student number below if child is over 21 and studying full time. If child is disabled, state nature of disability and attach full details. If adding an adopted child, provide date of adoption. If adding a legal ward, provide court document.
Mr.	T.	Form	05/06/1978	Married	M	☑ Health ☑ Dental	
Jr.	T.	Form	09/01/2013	Minor	F	☑ Health ☑ Dental	
						☐ Health ☐ Dental	
					X	☐ Health ☐ Dental	

Part 2: Spousal or Other Coverage

Are you or your dependents covered for extended health and/or dental benefits by another

☐ No ☑ Yes (specify)

Benefit	Name of Carrier/Policy #	Effective Date	ID Number	Coverage
Dental	PBC xxxxx	when spouse's plan started	000xxxxxx	☐ Single ☐ Couple ☑ Family
Health	PBC xxxxx	when spouse's plan started	000xxxxxx	☐ Single ☐ Couple ☑ Family

Employment type: ☑ Full-time ☐ Part-time ☐ Retiree

Part 3: Beneficiary Designation

Complete the following section to appoint a beneficiary for any benefits payable on your death.

Beneficiary for Basic Life/Optional Life/Basic AD&D Insurance (if applicable) Last Name First Name Initial	Date of Birth (MM/DD/YY)	Share of Proceeds	Relationship	Name of Trustee for Beneficiaries Under 18	Beneficiary Status[2]
THIS SECTION IS NOT APPLICABLE	N/A	N/A %	N/A	N/A	☐ Revocable ☐ Irrevocable
FOR TEACHERS AND ALLIED SPECIALISTS	N/A	N/A %	N/A	N/A	☐ Revocable ☐ Irrevocable
COMPLETE THE MANULIFE FORMS	N/A	N/A %	N/A	N/A	☐ Revocable ☐ Irrevocable
FOR LIFE INSURANCE	N/A	N/A %	N/A	N/A	☐ Revocable ☐ Irrevocable

Part 4: Personal Data Consent

Please see page 2 for further explanation

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 services provided from time to time.

I confirm that I have obtained consent from my spouse and any dependent children over the age of majority, to disclose their personal information to the Parties as required for the administration of the plan.

In the case of death, I expressly authorize my employer, the policyholder, the beneficiary, heir or liquidator of my estate to provide the Insurance companies, when required by the latter, with all the information and authorizations required for the processing of any claim(s).

I hereby apply for group benefits under my Plan Sponsor's/Employer's plan and authorize any required deductions. I certify that the information given above is true and complete. A photocopy of this authorization is as valid as the original. The original enrolment form will be retained by my Plan Sponsor/Employer.

Employee Signature: Example Form

Date Signed (MM/DD/YY): 09-Sep-2024

DO NOT FILL IN PART 5, THIS IS FOR THE EMPLOYER ONLY

Part 5: For Plan Administrator/Employer Use Only

Name of Employer / Organization	Employment Type	Division	Class[3]
Greater Victoria School District 61	☐ Full-time Permanent ☐ Part-time Permanent ☐ Temporary ☐ Retiree	1	1

Employee's Occupation/Position[4]	Annual Earnings	Date of Hire (MM/DD/YY)	Hours Worked Per Week[5]
	$ N/A		20

Dental		Extended Health		☑ Life ☐ AD&D (AD&D N/A for teachers and ASA)		☐ STD ☐ LTD (N/A for teachers and ASA)	
Waiting Period	Effective (MM/DD/YY)	Waiting Period	Effective (MM/DD/YY)	Waiting Period	Effective (MM/DD/YY)	Waiting Period	Effective (MM/DD/YY)
						N/A	N/A

Please note that this Enrolment Form also serves for enrolling employees, of participating groups, on to the BCPVPA disability plans (LTD and STD, where applicable).

---

[1] Please provide Employee ID/Payroll number. Please, do not use Social Insurance Number (SIN) as an employee ID.

[2] Beneficiary Status – The Beneficiary is considered revocable (can be changed in the future) unless otherwise stated. The Beneficiary can be made irrevocable, which means that if an employee wanted to change their beneficiary in the future they would require sign-off from the current beneficiary.

[3] If you have multiple classes under your plan, please indicate the class in which the employee should be enrolled.

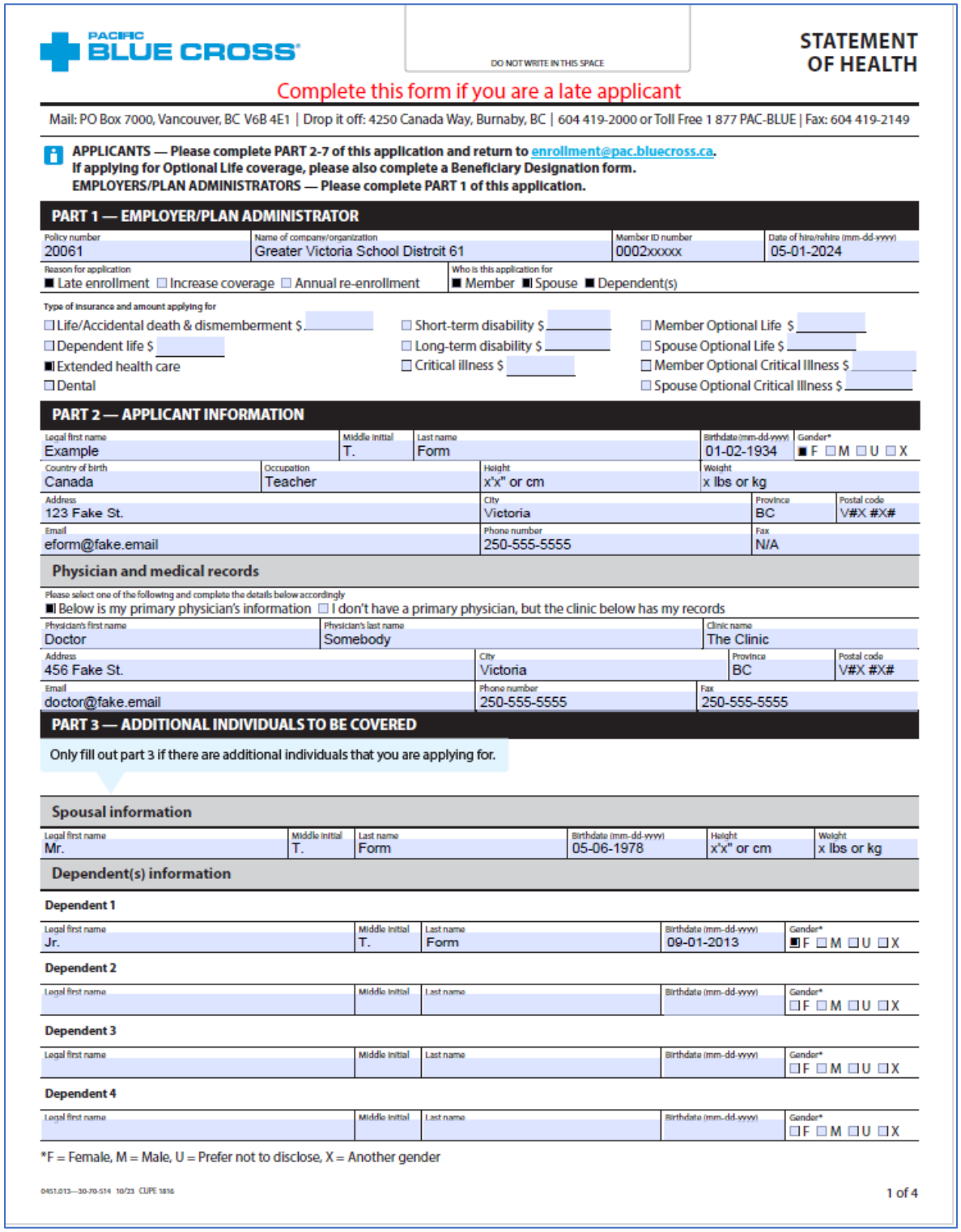
[4] Employee's Occupation/Position: please choose from the following:

- Teacher
- Teacher Teaching On-call
- Principal/Vice-Principal
- Superintendent/Assistant Superintendent
- Secretary Treasurer/Assistant Secretary Treasurer
- Senior Manager/Director
- Non-Unionized Support Staff (please specify)*

**Non-Unionized Support Staff, e.g., Executive Assistants, Speech Therapist, etc.*

[5] Hours Worked Per Week – for BCPVPA a minimum of 17.5 hours per week is required to be eligible for LTD.

7) Complete the PBC Statement of Health Forms (4 pages) (this applies to EHC only)



PACIFIC BLUE CROSS

DO NOT WRITE IN THIS SPACE

STATEMENT OF HEALTH

Complete this form if you are a late applicant

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

APPLICANTS — Please complete PART 2-7 of this application and return to 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)
20061	Greater Victoria School Distrcit 61	0002xxxxx	05-01-2024

Reason for application: ■ Late enrollment ☐ Increase coverage ☐ Annual re-enrollment

Who is this application for: ■ Member ■ Spouse ■ Dependent(s)

Type of insurance and amount applying for

- ☐ Life/Accidental death & dismemberment $ ____
- ☐ Dependent life $ ____
- ■ Extended health care
- ☐ Dental
- ☐ Short-term disability $ ____
- ☐ Long-term disability $ ____
- ☐ Critical illness $ ____
- ☐ Member Optional Life $ ____
- ☐ Spouse Optional Life $ ____
- ☐ Member Optional Critical Illness $ ____
- ☐ Spouse Optional Critical Illness $ ____

PART 2 — APPLICANT INFORMATION

Legal first name	Middle initial	Last name	Birthdate (mm-dd-yyyy)	Gender*
Example	T.	Form	01-02-1934	■ F ☐ M ☐ U ☐ X

Country of birth	Occupation	Height	Weight
Canada	Teacher	x'x" or cm	x lbs or kg

Address	City	Province	Postal code
123 Fake St.	Victoria	BC	V#X #X#

Email	Phone number	Fax
eform@fake.email	250-555-5555	N/A

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
Doctor	Somebody	The Clinic

Address	City	Province	Postal code
456 Fake St.	Victoria	BC	V#X #X#

Email	Phone number	Fax
doctor@fake.email	250-555-5555	250-555-5555

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
Mr.	T.	Form	05-06-1978	x'x" or cm	x lbs or kg

Dependent(s) information

Dependent 1

Legal first name	Middle initial	Last name	Birthdate (mm-dd-yyyy)	Gender*
Jr.	T.	Form	09-01-2013	■ F ☐ M ☐ U ☐ X

Dependent 2

Legal first name	Middle initial	Last name	Birthdate (mm-dd-yyyy)	Gender*
				☐ F ☐ M ☐ U ☐ X

Dependent 3

Legal first name	Middle initial	Last name	Birthdate (mm-dd-yyyy)	Gender*
				☐ F ☐ M ☐ U ☐ X

Dependent 4

Legal first name	Middle initial	Last name	Birthdate (mm-dd-yyyy)	Gender*
				☐ F ☐ M ☐ U ☐ X

*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)	☐ Yes ■ No	☒ Yes ☐ No
2. Has your weight decreased more than 4.5 kg or 10 lbs in the past year?	☐ Yes ■ No	☒ Yes ☐ No

	If yes, how much weight was lost?	Reason(s) for weight loss
Member		
Spouse		

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) **Dependents** Fill this out if this applies to 1 or more of your dependents. You do not need to identify which dependent. ☐ Yes ☐ No If yes, provide details	☐ Yes ■ No	☐ Yes ☐ No

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) **Cardiovascular or circulatory** including vascular disease, high blood pressure, elevated cholesterol, heart attack, angina, stroke or TIA (mini-stroke) and blood disorders.	☐ Yes ■ No	☒ Yes ☐ No	☒ Yes ☐ No
b) **Diabetes / Endocrine disorders** including Type 1 or Type 2, hormonal or thyroid conditions.	☐ Yes ■ No	■ Yes ☐ No	☒ Yes ☐ No
c) **Gastrointestinal conditions** 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).	☐ Yes ■ No	☐ Yes ■ No	☒ Yes ☐ No
d) **Respiratory or Lung conditions** including Allergies, Asthma, Bronchitis, Chronic Obstructive Pulmonary Disease (COPD), Sleep Apnea.	☐ Yes ■ No	☐ Yes ■ No	☒ Yes ☐ No
e) **Musculoskeletal conditions** including Osteoarthritis or Rheumatoid Arthritis, Osteoporosis, bone density loss or back, neck, limb or joint pain (including Fibromyalgia).	☐ Yes ■ No	☐ Yes ■ No	☒ Yes ☐ No
f) **Immunological conditions** 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.	☐ Yes ■ No	☐ Yes ■ No	☐ Yes ■ No
g) **Genitourinary conditions** including kidney, bladder, infertility or Reproductive Disorders, Menopause, Endometriosis, Sexually Transmitted Disease(s) or recurring infections (cold sore/ Herpes/Shingles).	☐ Yes ■ No	☐ Yes ■ No	☐ Yes ■ No
h) **Neurological conditions** including Alzheimer's, Dementia, Parkinson's, epilepsy, Multiple Sclerosis, Seizures, Paralysis, chronic headaches or migraines, or Chronic Fatigue Syndrome.	☐ Yes ■ No	☐ Yes ■ No	☐ Yes ■ No
i) **Mental or Nervous conditions** including Anxiety, Depression, Emotional Disorders, Eating Disorders, Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD).	☐ Yes ■ No	☐ Yes ■ No	☐ Yes ■ No
j) **Cancer and Tumors** including malignant or benign, leukemia.	☐ Yes ■ No	☐ Yes ■ No	☐ Yes ■ No
k) **Drugs** including ever used narcotics, stimulants, hallucinogens or other drugs except those that were prescribed by a physician.	☐ Yes ■ No	☐ Yes ■ No	☐ Yes ■ 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?	☐ Yes ■ No	☐ Yes ■ No	☐ Yes ■ 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	☐ Yes ■ No	☐ Yes ■ No	☐ Yes ■ 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: Mr. T. Form	Diagnosis date (mm-dd-yyyy): 07-11-2024	■ Same physician as in part 2.3	
Condition/disorder: Diabetes		Physician name	
Medication/treatment: Insulin		Address	
Recovery date (mm-dd-yyyy): N/A		Email	Phone number
Name of individual	Diagnosis date (mm-dd-yyyy)	☐ 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)	☐ 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.

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 X Example Form	Date (mm-dd-yyyy) 09-09-2024
Spouse signature X Mr. Form	Date (mm-dd-yyyy) 09-09-2024

PART 7 — MIB, LLC PRE-NOTICE

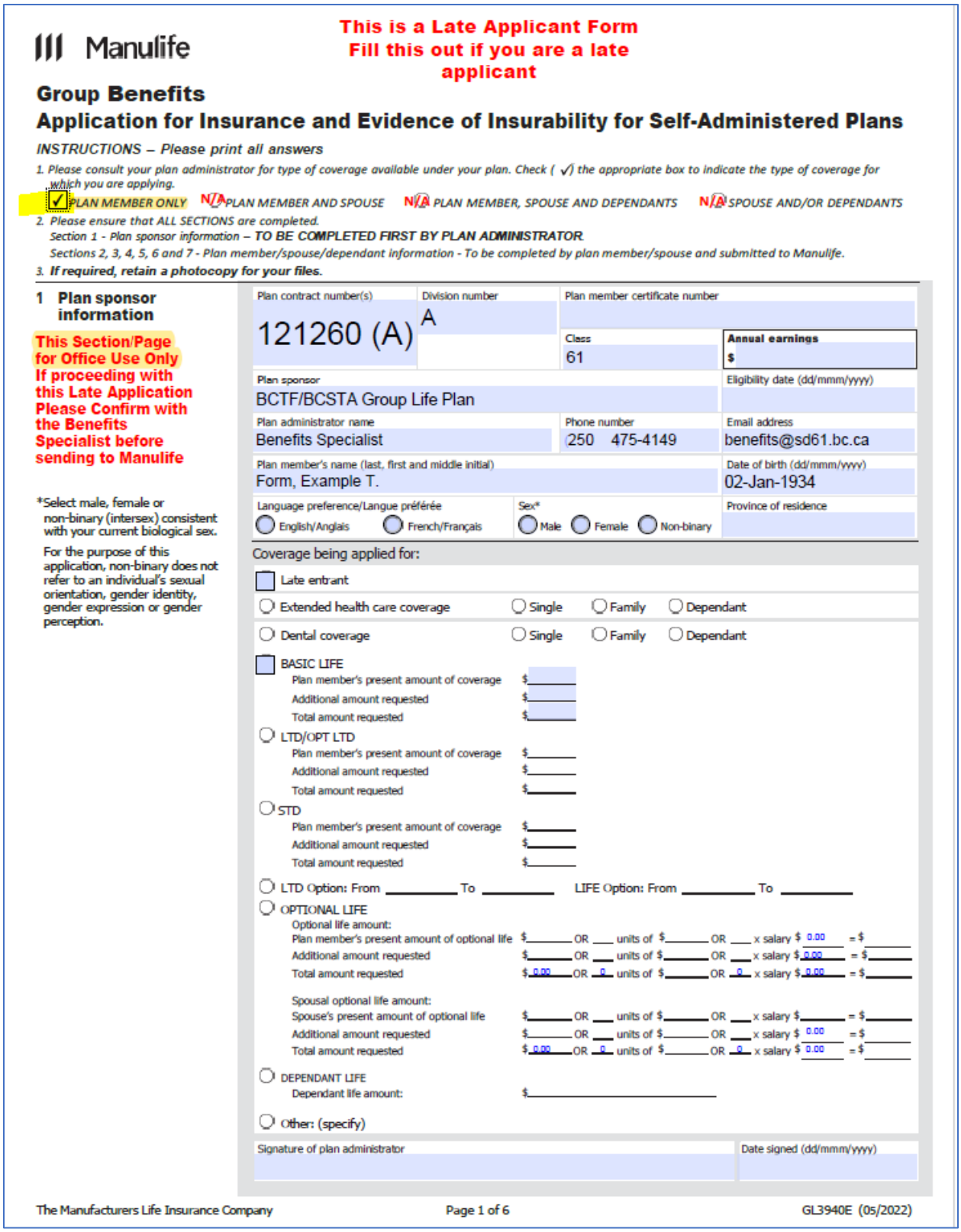
IMPORTANT: Please read carefully.

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

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.

8) Complete the **Late** Manulife Enrollment Forms *(If you don't want group life, complete the refusal form)*



Manulife

This is a Late Applicant Form
Fill this out if you are a late applicant

Group Benefits
Application for Insurance and Evidence of Insurability for Self-Administered Plans

INSTRUCTIONS – Please print all answers

1. *Please consult your plan administrator for type of coverage available under your plan. Check (✓) the appropriate box to indicate the type of coverage for which you are applying.*

☑ PLAN MEMBER ONLY N/A PLAN MEMBER AND SPOUSE N/A PLAN MEMBER, SPOUSE AND DEPENDANTS N/A SPOUSE AND/OR DEPENDANTS

2. *Please ensure that ALL SECTIONS are completed.*
   Section 1 - Plan sponsor information – TO BE COMPLETED FIRST BY PLAN ADMINISTRATOR.
   Sections 2, 3, 4, 5, 6 and 7 - Plan member/spouse/dependant information - To be completed by plan member/spouse and submitted to Manulife.
3. ***If required, retain a photocopy for your files.***

1 Plan sponsor information

This Section/Page for Office Use Only If proceeding with this Late Application Please Confirm with the Benefits Specialist before sending to Manulife

*Select male, female or non-binary (intersex) consistent with your current biological sex.

For the purpose of this application, non-binary does not refer to an individual's sexual orientation, gender identity, gender expression or gender perception.

Plan contract number(s)	Division number	Plan member certificate number	
121260 (A)	A		
		Class: 61	Annual earnings: $
Plan sponsor: BCTF/BCSTA Group Life Plan			Eligibility date (dd/mmm/yyyy)
Plan administrator name: Benefits Specialist		Phone number: 250 475-4149	Email address: benefits@sd61.bc.ca
Plan member's name (last, first and middle initial): Form, Example T.			Date of birth (dd/mmm/yyyy): 02-Jan-1934
Language preference/Langue préférée: ◯ English/Anglais ◯ French/Français		Sex*: ◯ Male ◯ Female ◯ Non-binary	Province of residence

Coverage being applied for:

☐ Late entrant

◯ Extended health care coverage ◯ Single ◯ Family ◯ Dependant

◯ Dental coverage ◯ Single ◯ Family ◯ Dependant

☐ BASIC LIFE
- Plan member's present amount of coverage $_____
- Additional amount requested $_____
- Total amount requested $_____

◯ LTD/OPT LTD
- Plan member's present amount of coverage $_____
- Additional amount requested $_____
- Total amount requested $_____

◯ STD
- Plan member's present amount of coverage $_____
- Additional amount requested $_____
- Total amount requested $_____

◯ LTD Option: From _____ To _____ LIFE Option: From _____ To _____

◯ OPTIONAL LIFE

Optional life amount:
- Plan member's present amount of optional life $_____ OR ___ units of $_____ OR ___ x salary $ 0.00 = $_____
- Additional amount requested $_____ OR ___ units of $_____ OR ___ x salary $ 0.00 = $_____
- Total amount requested $ 0.00 OR 0 units of $_____ OR 0 x salary $ 0.00 = $_____

Spousal optional life amount:
- Spouse's present amount of optional life $_____ OR ___ units of $_____ OR ___ x salary $_____ = $_____
- Additional amount requested $_____ OR ___ units of $_____ OR ___ x salary $ 0.00 = $_____
- Total amount requested $ 0.00 OR 0 units of $_____ OR 0 x salary $ 0.00 = $_____

◯ DEPENDANT LIFE
- Dependant life amount: $_____

◯ Other: (specify)

Signature of plan administrator	Date signed (dd/mmm/yyyy)

2 Plan member statement

*Select male, female or non-binary (intersex) consistent with your current biological sex.

For the purpose of this application, non-binary does not refer to an individual's sexual orientation, gender identity, gender expression or gender perception.

Plan member's name (last, first and middle initial): Form, Example T.

Occupation: Teacher

Sex*: ○ Male ◉ Female ○ Non-binary

Date of birth (dd/mmm/yyyy): 02-Jan-1934

Home phone number: 250-555-5555

Business phone number: 250-555-5555

Plan member's address (number, street, apartment): 123 Fake St.

City: Victoria

Province: BC

Postal code: V#X #X#

Height: x ____ m ____ ft x ____ cm ____ in

Weight: X ◉ kg ○ lb

Have you smoked (cigarettes, cigars, pipe, etc) or used tobacco in any other forms or any smoking cessation aids within the last 12 months? ○ Yes ◉ No

Have you lost or gained more than 4.5 kg/10 lbs during the last 12 months? ○ Yes ◉ No If yes, please answer the following:

What was the amount of weight change? N/A ○ kg ○ lb

Was this a gain or a loss? N/A

Reason: N/A

Name of personal physician (last, first and middle initial): Doctor Somebody

Address of personal physician (number, street, suite): 456 Fake St.

Physician's phone number: 250-555-5555

City: Victoria

Province: BC

Postal code: V#X #X#

3 Spousal statement

N/A for SD61

*Select male, female or non-binary (intersex) consistent with your current biological sex.

For the purpose of this application, non-binary does not refer to an individual's sexual orientation, gender identity, gender expression or gender perception.

Spouse's name (last, first and middle initial): N/A

Sex*: ○ Male ○ Female ○ Non-binary

Date of birth (dd/mmm/yyyy):

Home phone number: ( )

Business phone number: ( )

Height: ____ m ____ ft ____ cm ____ in

Weight: ○ kg ○ lb

Have you smoked (cigarettes, cigars, pipe, etc) or used tobacco in any other forms or any smoking cessation aids within the last 12 months? ○ Yes ○ No

Have you lost or gained more than 4.5 kg/10 lbs during the last 12 months? ○ Yes ○ No If yes, please answer the following:

What was the amount of weight change? ○ kg ○ lb

Was this a gain or a loss?

Reason:

Name of personal physician (last, first and middle initial):

Address of personal physician (number, street, suite):

Physician's phone number: ( )

City:

Province:

Postal code:

4 Dependant information

N/A for SD61

Please provide the following information for each dependant to be insured.
If you have more than three children, please attach separate sheet (signed and dated) and include all personal information as requested above.

*Select male, female or non-binary (intersex) consistent with your current biological sex.

For the purpose of this application, non-binary does not refer to an individual's sexual orientation, gender identity, gender expression or gender perception.

Child's name (last, first and middle initial)
N/A

Sex*	Date of birth (dd/mmm/yyyy)	Height	Weight
◯ Male ◯ Female ◯ Non-binary		____ m ____ cm ____ ft ____ in	◯ kg ◯ lb

Have you lost or gained more than 4.5 kg/10 lbs during the last 12 months? ◯ Yes ◯ No If *yes*, please answer the following:

What was the amount of weight change?	Was this a gain or a loss?	Reason
◯ kg ◯ lb		

Dependant physician - Is name of personal physician the same as member? ◯ Yes ◯ No If *no*, please provide:

Name of personal physician (last, first and middle initial)

Address of personal physician (number, street, suite)		Physician's phone number
		( )
City	Province	Postal code

*Select male, female or non-binary (intersex) consistent with your current biological sex.

For the purpose of this application, non-binary does not refer to an individual's sexual orientation, gender identity, gender expression or gender perception.

Child's name (last, first and middle initial)
N/A

Sex*	Date of birth (dd/mmm/yyyy)	Height	Weight
◯ Male ◯ Female ◯ Non-binary		____ m ____ cm ____ ft ____ in	◯ kg ◯ lb

Have you lost or gained more than 4.5 kg/10 lbs during the last 12 months? ◯ Yes ◯ No If *yes*, please answer the following:

What was the amount of weight change?	Was this a gain or a loss?	Reason
◯ kg ◯ lb		

Dependant physician - Is name of personal physician the same as member? ◯ Yes ◯ No If *no*, please provide:

Name of personal physician (last, first and middle initial)

Address of personal physician (number, street, suite)		Physician's phone number
		( )
City	Province	Postal code

*Select male, female or non-binary (intersex) consistent with your current biological sex.

For the purpose of this application, non-binary does not refer to an individual's sexual orientation, gender identity, gender expression or gender perception.

Child's name (last, first and middle initial)
N/A

Sex*	Date of birth (dd/mmm/yyyy)	Height	Weight
◯ Male ◯ Female ◯ Non-binary		____ m ____ cm ____ ft ____ in	◯ kg ◯ lb

Have you lost or gained more than 4.5 kg/10 lbs during the last 12 months? ◯ Yes ◯ No If *yes*, please answer the following:

What was the amount of weight change?	Was this a gain or a loss?	Reason
◯ kg ◯ lb		

Dependant physician - Is name of personal physician the same as member? ◯ Yes ◯ No If *no*, please provide:

Name of personal physician (last, first and middle initial)

Address of personal physician (number, street, suite)		Physician's phone number
		( )
City	Province	Postal code

6 Medical questions for proposed insured

COMPLETE ALL QUESTIONS BELOW on behalf of ALL applicants. Provide full details to ALL YES QUESTIONS. If you require more room for YES answers please attach a separate sheet (signed and dated).

	Plan member	Spouse	Children
1. During the past 12 months have you			
(a) flown as a pilot, student pilot or crew member or have any intention of doing so?	◯ Yes ◉ No	◯ Yes ◯ No	◯ Yes ◯ No
(b) engaged in racing, underwater diving, parachuting or any other hazardous sport or have any intention of doing so?	◯ Yes ◉ No	◯ Yes ◯ No	◯ Yes ◯ No
2. Have you			
(a) ever applied for or received benefits, compensation or pension because of sickness or injury?	◯ Yes ◉ No	◯ Yes ◯ No	◯ Yes ◯ No
(b) ever had an application for life or health insurance declined, postponed, or modified in any way?	◯ Yes ◉ No	◯ Yes ◯ No	◯ Yes ◯ No
(c) been absent from work for medical reasons during the last 5 years?	◯ Yes ◉ No	◯ Yes ◯ No	◯ Yes ◯ No
(d) currently received any treatment/medications?	◯ Yes ◉ No	◯ Yes ◯ No	◯ Yes ◯ No
(e) any condition which might require medical consultation, hospitalization or future surgical or psychiatric treatment?	◯ Yes ◉ No	◯ Yes ◯ No	◯ Yes ◯ No
3. Have you ever consulted a physician, ever been treated for, or had any known identification of			
(a) chest pain, blood vessel disease, heart disorder, or heart attack or stroke?	◯ Yes ◉ No	◯ Yes ◯ No	◯ Yes ◯ No
(b) high blood pressure?	◯ Yes ◉ No	◯ Yes ◯ No	◯ Yes ◯ No
(c) allergies or skin disorders, including growths, cysts or tumours?	◯ Yes ◉ No	◯ Yes ◯ No	◯ Yes ◯ No
(d) glandular disorders, including thyroid disorders and diabetes?	◯ Yes ◉ No	◯ Yes ◯ No	◯ Yes ◯ No
(e) epilepsy, neurological disorder (e.g. Multiple Sclerosis, Parkinson's)?	◯ Yes ◉ No	◯ Yes ◯ No	◯ Yes ◯ No
(f) nervous or mental disorder or an emotional condition such as anxiety or depression?	◯ Yes ◉ No	◯ Yes ◯ No	◯ Yes ◯ No
(g) excessive use of alcohol or drugs?	◯ Yes ◉ No	◯ Yes ◯ No	◯ Yes ◯ No
(h) lung disorders?	◯ Yes ◉ No	◯ Yes ◯ No	◯ Yes ◯ No
(i) bowel, stomach or liver disorders?	◯ Yes ◉ No	◯ Yes ◯ No	◯ Yes ◯ No
(j) cancer?	◯ Yes ◉ No	◯ Yes ◯ No	◯ Yes ◯ No
(k) disorder of the kidney, urine or genital organs?	◯ Yes ◉ No	◯ Yes ◯ No	◯ Yes ◯ No
(l) arthritis, rheumatism or fibromyalgia?	◯ Yes ◉ No	◯ Yes ◯ No	◯ Yes ◯ No
(m) disorders of the muscles or bones including the back, spine or joints?	◯ Yes ◉ No	◯ Yes ◯ No	◯ Yes ◯ No
(n) immune deficiency disorder including AIDS or AIDS-related complex (ARC) or any generalized enlargement of the lymph glands or any test results indicating possible exposure to the AIDS (e.g. HTLV-III, LAV) virus?	◯ Yes ◉ No	◯ Yes ◯ No	◯ Yes ◯ No
(o) anemia, or other blood disorders?	◯ Yes ◉ No	◯ Yes ◯ No	◯ Yes ◯ No
4. Have you ever had any physical impairment, condition, disease or disorder or chronic symptoms including Chronic Fatigue Syndrome or chronic pain not covered above?	◯ Yes ◉ No	◯ Yes ◯ No	◯ Yes ◯ No

5 Medical questions for proposed insured (continued)

Please provide details below, if you have answered YES to *ANY* questions.
If more space is needed, use another form or sheet of paper (both must be signed and dated).

Question number	Name of person (first & middle initial)	Details or name of condition	Date and duration	Medication/treatment and results (recovery or remaining effects)	Names and addresses of physicians and hospitals

	Plan member	Spouse	Children
5. Have any of your immediate family members (parents, sisters, brothers) been diagnosed with cancer, heart disease, diabetes (2 or more family members prior to age 50), chronic kidney disease, angina, stroke, multiple sclerosis, Huntington's disease, Parkinson's disease, Alzheimer's disease, Amyotrophic Lateral Sclerosis (Lou Gehrig's disease) or motor neuron disease prior to age 60? If answered *yes*, please provide details in the chart below.	(•) Yes ( ) No	( ) Yes ( ) No	( ) Yes ( ) No

Plan member or spouse's family member	Relationship	Condition	Age at onset	Age at death (if applicable)
[✓] Plan member ( ) Spouse ( ) Child	Mother	Heart Disease	60	80
[ ] Plan member ( ) Spouse ( ) Child				
[ ] Plan member ( ) Spouse ( ) Child				
[ ] Plan member ( ) Spouse ( ) Child				

6 Certification and authorization

I certify that I (being the plan member, spouse or dependant with the capacity to contract, whichever is applicable) am applying for this Group Benefits coverage/insurance ("Coverage") and that the information provided for this application is true and complete. **I agree** that my coverage may be denied or terminated at any time as a result of any false, incomplete, or misleading information having been provided in this application. **I authorize** Manulife to collect, use, maintain and disclose my personal information relevant to this application ("Information") for the purposes of Group Benefits plan administration, audit and the assessment, investigation, or management of this application, and medical underwriting (collectively, the "Purposes"). **I am authorized** to consent to the collection, use, maintenance, exchange and disclosure of Information pertaining to any minor child who may be the subject of this application for Coverage, for the Purposes, and all of the statements made herein on my own behalf shall apply equally to such minor child. **I understand** that Manulife may investigate this application and may require Information about me for the Purposes, including information regarding activities, income, employment, education and training, health and medical history and treatment, including clinical notes. **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with Manulife, its reinsurers and/or its service providers, for the Purposes. **I understand** that any Coverage shall not become effective until approved by Manulife.

I authorize the use of my Social Insurance Number ("SIN") for the purposes of identification and administration, if my SIN is used as my plan member certificate number. **I agree** a photocopy or electronic version of this authorization is valid. **I acknowledge** that more specific details regarding how and why Manulife collects, uses, maintains, and discloses my personal information can be found in Manulife's Privacy Policy and Privacy Information Package, available at www.manulife.ca/planmember, or from my Plan Sponsor.

Plan member's name (please print)

Form, Example T.

Signature of plan member	Date signed (dd/mmm/yyyy)
Example Form	09-Sep-2024
Signature of spouse (required only if evidence regarding insurability of spouse is provided in this form) N/A	Date signed (dd/mmm/yyyy)

Any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a Group Benefits life, health or disability file. Access to your Information will be limited to:

- Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs;
- persons to whom you have granted access; and
- persons authorized by law.

You have the right to request access to the personal information in your file, and, where appropriate, to have any inaccurate information corrected.

7 Mailing instructions

Please send the completed form to:

Group Medical Underwriting
Manulife
PO BOX 1900, STATION C
KITCHENER ON N2G 4R4

Phone: 1-800-268-6195 or 519-747-7000

Plan Member Website: Use the link under Contact Us in the main menu to send us your documents securely using the Send Documents feature.

9) Double check that you have filled in and signed all required spaces on your forms.
10) Save your forms to an easily accessible folder or your desktop.
11) Email only the required, completed and signed, forms to beneifts@sd61.bc.ca.