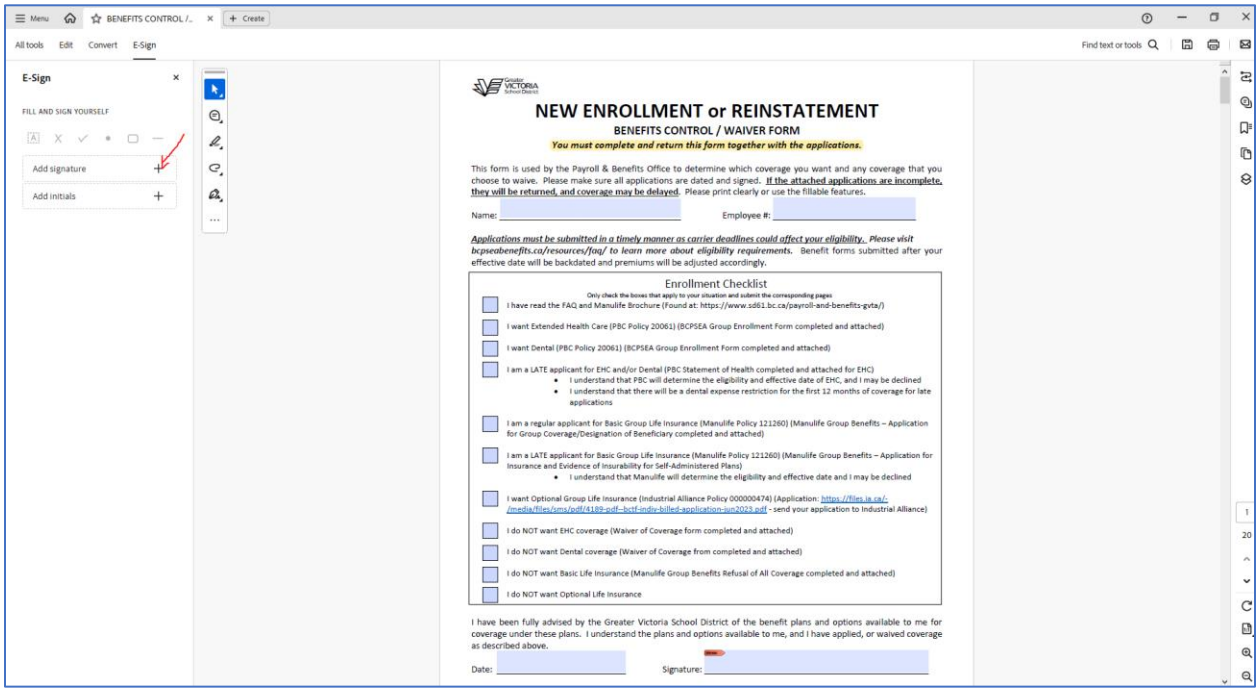
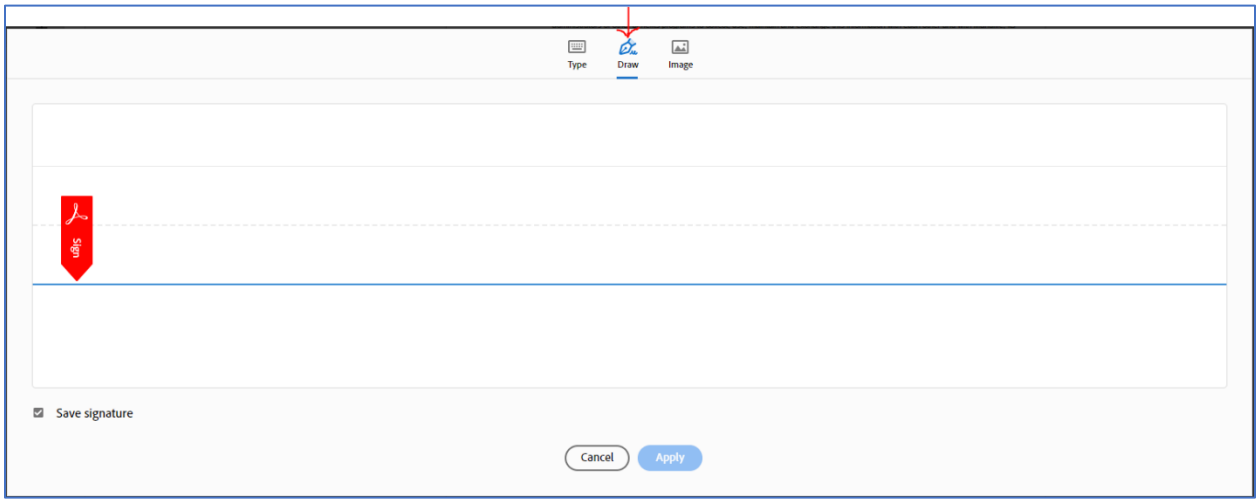
How to fill in and submit your benefits forms in 10 steps (regular applicant):

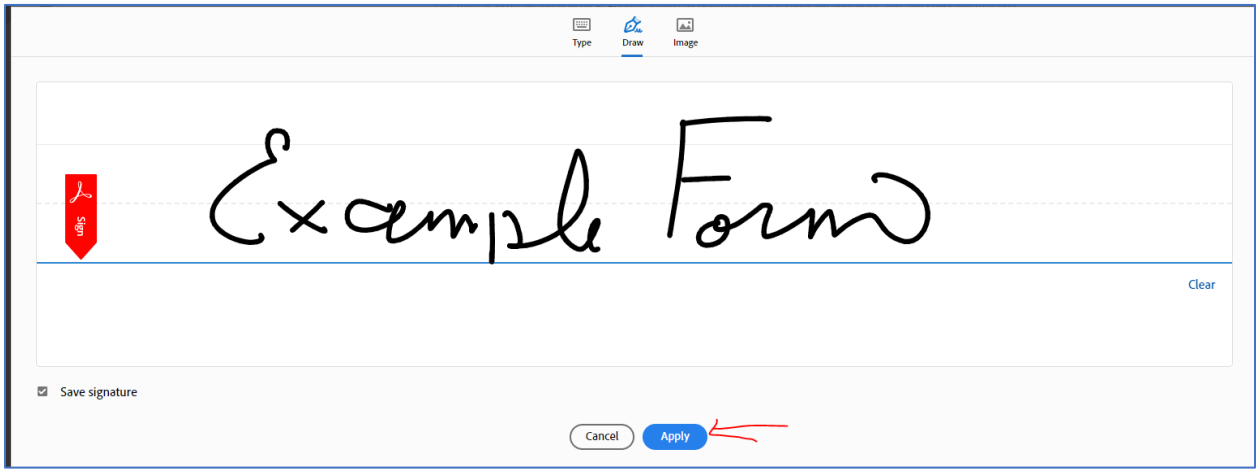
1) Download and read the FAQ from the website: https://www.sd61.bc.ca/payroll-and-benefits-gvta/.
2) Download and read through the New Enrollment or Reinstatement application package.
3) Open the blank form with Adobe.
4) Create a signature in Adobe.
    a. Select E-sign; Add signature.



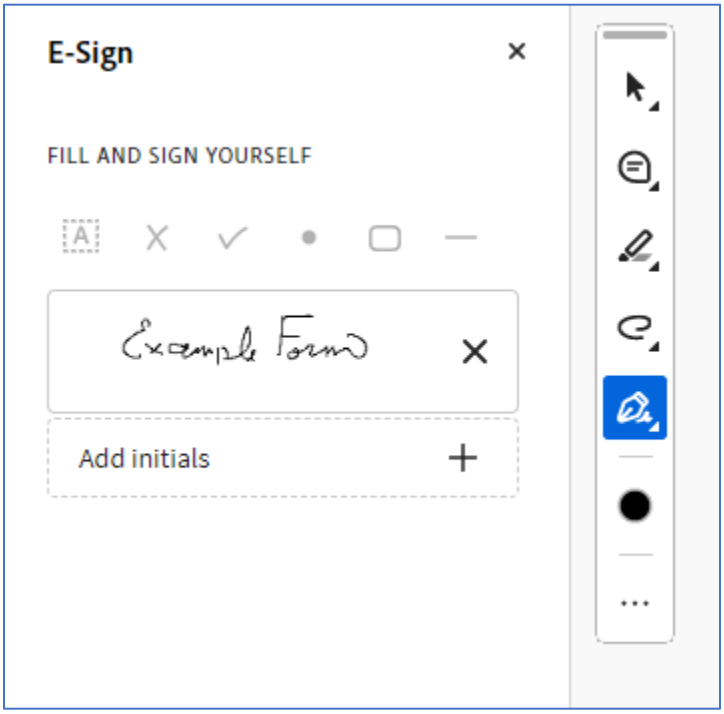
    b. Select Draw.



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)
- [ ] 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
- [x] 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)
- [ ] 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

Dependants (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	
						☐ Health ☐ Dental	

Part 2: Spousal or Other Coverage

Are you or your dependants 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).

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[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 Manulife Enrollment Form (2 pages) *(If you don't want group life, complete the refusal form)*

This is a regular applicant form

Manulife

Please see reverse for assistance in completing this form.
Please send the completed form to your Plan Administrator.

Group Benefits – Application for Group Coverage/Designation of Beneficiary

(•) Enrolment and Initial Beneficiary Designation
( ) Change of Beneficiary

All sections of this page should be completed as it will replace any prior designations.

Section 1 is to be completed by the plan administrator. The remaining sections are to be completed by the plan member. Please print clearly in dark ink using CAPITAL LETTERS.

1 Plan sponsor statement

To be completed by plan administrator.

Plan sponsor name: BCTF/BCSTA Group Life Plan
Plan contract number: 121260
Location/Class: 61
Plan member certificate number (SIN Number):
Hire date (dd/mmm/yyyy):
Plan: A

Note: Hire Date only required if form is being used for Enrolment & Initial Beneficiary Designation.

2 Plan member information

Plan member name (last, first and middle initial): Form, Example T.
Province of residence: BC
Date of birth (dd/mmm/yyyy): 02-Jan-1934

3 Primary beneficiary

List all primary beneficiaries for Basic Life.
Percentages must total 100%.

Name of beneficiary (last, first and middle initial)	Date of birth (dd/mmm/yyyy)	Relationship to plan member	Percentage
Form, Mr. T.	06-May-1978	Married	100%

Irrevocability

Note: If beneficiary is shown as irrevocable, his/her consent is required to change it. Include a signed and dated consent with this form. **You are responsible for ensuring the validity of your designation.**

For Quebec residents only

In Quebec, the designation of your spouse as beneficiary is irrevocable unless otherwise specified.
If spouse is beneficiary, the designation is:
( ) **Revocable** ( ) **Irrevocable**

4 Contingent beneficiary

You may wish to designate a contingent beneficiary(ies) to receive any proceeds under this group policy if all of the primary beneficiary(ies), named above, should die before you. In that event, a contingent beneficiary will automatically be entitled to the benefit that would have been payable to the primary beneficiary(ies). If you name more than one contingent beneficiary, then the proceeds will be split, evenly, amongst the contingent beneficiaries you choose to name. Should there not be any surviving beneficiaries at the time of your death, the proceeds will be paid to your estate.

Name of contingent beneficiary (last, first and middle initial)	Date of birth (dd/mmm/yyyy)	Relationship to plan member
Form, Jr. T.	01-Sep-2013	Child

5 Trustee appointment

Complete if any beneficiary named is under the age of majority.

I appoint Sister T. Form as Trustee to receive any amount due to any beneficiary under the age of majority (not applicable in Quebec).

Continued on the next page.

6 Declaration and authorization

Enrolment

I hereby apply for coverage ("Coverage") under the Group Benefits plan issued to my plan sponsor by Manulife. **I understand** that certain aspects of such Coverage may extend to my spouse and eligible dependants (collectively, "Dependants"). **I certify** that the information in this form is true and complete to the best of my knowledge. **I understand** that as the applicant, it is my responsibility to ensure that any further verbal or written statement provided by me, and/or my Dependants, in the future is true and complete to the best of our knowledge. **I acknowledge and agree** that this Coverage or any portion of this Coverage, and future claims thereunder may be denied or terminated as a result of the provision of false, incomplete, or misleading information.

I authorize Manulife to collect, use, maintain and disclose personal information relevant to this application ("Information") for the purposes of Group Benefits plan administration, audit, assessment, investigation, claim management, underwriting and for determining plan eligibility ("Purposes"). **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 am authorized by my Dependants to consent to this Authorization, on their behalf as if they were signing it themselves, and to disclose and receive their Information, for the Purposes. **I authorize** my plan sponsor to make deductions from my pay for my Group Benefits plan, if applicable. **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 understand that 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 my Information will be limited to:

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

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

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.

Beneficiary Designation

I hereby revoke any previous beneficiary designations in relation to my foregoing coverage(s) and designate the person(s) named above.

I authorize Manulife to collect, use, maintain and disclose personal information relevant to this designation ("Information") for the purposes of Group Benefits plan administration, audit, assessment, investigation, and claim management ("Purposes"). **I authorize** any person or organization with Information, including any 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 acknowledge that more detailed information concerning how and why Manulife collects, uses and discloses my personal information is available at www.manulife.ca/planmember, or by requesting a copy from my plan sponsor.

I agree a photocopy or electronic version of this authorization is valid.

Plan member signature: Example Form — Date signed (dd/mmm/yyyy): 09-Sep-2024

Due to the legal significance of a beneficiary appointment this designation must be signed and dated to be valid.
A copy, fax, scan or image of the beneficiary designation in this form is as valid as the original.

Continued on the next page.

PRINT

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