ADDITION OF ELIGIBLE DEPENDENTS

BENEFITS CONTROL / WAIVER FORM - CUPE

You must complete and return this form together with the Change Forms.

This form is used by the Payroll & Benefits Office to determine which coverage you want for your dependent(s) 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: _____ Employee #: _____

Applications must be submitted within 31 days and not more than 4 months from your eligibility date. Benefits forms submitted after the first of the following month will be back dated and premiums will be adjusted.

Eligible dependents include your spouse, and any unmarried dependent children. Legal, common-law, and same sex spouses are eligible. Common-law spouses are eligible after cohabitation for a period of one year.

Enrollment Checklist

Only check the boxes that apply to your situation

- ☐ I have read and understood the CUPE 947 BENEFITS information, FAQs - including Summer Premium Calculations (found:https://www.sd61.bc.ca/payroll-and-benefits-947/)
- ☐ I am enrolling an eligible student (I have read the Over-age Dependent rules and I have attached a confirmation of enrollment letter from the post-secondary institution)
- ☐ I am enrolling a Common-Law Spouse (Common – Law Spouse declaration completed and attached)
- ☐ I want Extended Health Care for my dependents (PEBT Benefits Change Form completed and attached)
- ☐ I want Dental for my dependents (PEBT Benefits Change Form completed and attached)
- ☐ My dependents have lost coverage from another plan (Transfer Form completed and attached)
- ☐ This is a LATE application (Statement of Health completed and attached for EHC)
  - I understand that PBC will determine the eligibility and effective date of EHC for my dependent and that they maybe declined
  - I understand that there will be a dental expense restriction for the first 12 months of coverage for late applications
- ☐ My dependents do NOT need EHC coverage (Waiver of Coverage form completed and attached)
- ☐ My dependents do NOT need Dental coverage (Waiver of Coverage form completed and attached)

I have been fully advised by the Greater Victoria School District of the benefit plans and options available to me for coverage under these plans. I understand the plans and options available to me, and I have applied, or waived coverage as described above.

Date: _____ Signature: _____

The information collected on this form is required and will be used by School District No. 61 solely for purposes of benefit plan administration. It will be kept secure and confidential in accordance with the Freedom of Information and Protection of Privacy Act.
The information will also be used by the organizations that provide the benefits plans, as explained on the form that is used by the plan carrier. Any questions concerning the collection or use of this information by the School District may be addressed to: Payroll and Benefits Coordinator, Greater Victoria School District No. 61.

PUBLIC EDUCATION BENEFITS TRUST

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) _____

Benefits Change Form

The appropriate section(s) below should only be completed as changes to the Benefits Enrolment Form are required. Once completed, the benefits administrator should file this form for future reference.

Part 1: Employee Identification

Employee's Last Name	First Name	Initial	District #	Employee ID number	Provincial Health Plan Number (Care Card)

Part 2: Change in Family Status

Change of coverage requested due to the following "event":

Date of Event (yyyy/mm/dd)

○ Marriage ○ Cohabitation ○ Divorce ○ Separation ○ Death ○ Birth ○ Adoption

◉ Other (specify):

Revised Extended Health Coverage	Revised Dental Coverage
○ Single ○ Couple ○ Family ○ Waived (attach Waiver of Coverage form)	○ Single ○ Couple ○ Family ○ Waived (attach Waiver of Coverage form)

Add	Delete	No.	Dependent's First Name	Initial	Last Name (if different from Employee)	Birthdate (yyyy/mm/dd)	Relationship	Gender M – Male F – Female X – Another Gender U – Prefer Not to Disclose	Provide name of school **and student number** if child is over 21 and studying full-time. If child is disabled, indicate "disabled" in this section and attach the approved CRA/PWD (Persons with Disability) document. If adding an adopted child, provide date of adoption. If adding a legal ward, provide court document.
○	○								
○	○								
○	○								
○	○								
○	○								

Part 3: Change to Spousal or Other Coverage

Change of ☐ Dental ☐ Extended Health coverage requested due to:

Date of Change (yyyy/mm/dd)

○ Spouse's plan terminated – enrol on PEBT plan (ensure Group Insurance Application is up to date or note additions on this form)

○ Transferring to Spouse's plan - terminate from PEBT plan by completing Waiver of Coverage Form. Spouse's policy number: _____

Revised Extended Health Coverage:	Revised Dental Coverage:
○ Single ○ Couple ○ Family ○ Waived (attach Waiver of Coverage form)	○ Single ○ Couple ○ Family ○ Waived (attach Waiver of Coverage form)

Part 4: Change of Beneficiary Designation

New Beneficiary - Last Name	First Name	Initial	Share of Proceeds %	Relationship	Name of Trustee for Beneficiaries Under 18
			%		
			%		

To which benefit(s) does this change apply? ○ All applicable benefits, or: ○ Basic Life ○ Optional Life ○ Basic AD&D ○ Optional AD&D

Part 5: Change of Name

Previous Last Name	First Name	Initial	Date of Change (yyyy/mm/dd)

New Last Name	First Name	Initial	
			○ Employee ○ Dependent

I hereby confirm the above information is complete, true and correct. I understand that if this application is completed more than 31 days after the loss of extended health and/or dental coverage through another plan, or 4 months after the addition of an eligible dependent that changes my family status, satisfactory evidence of insurability will be required to add dependents to this plan. I reserve the right to change my beneficiary at any time.

Employee Signature _____ Date Signed (yyyy/mm/dd)_____

Waiver of Coverage

This form must be completed and signed by any employee who decides to waive Extended Health or Dental benefits because they have coverage under a spouse's plan or by any employee wishing to waive coverage while on a Leave of Absence, Maternity, Parental or EI Compassionate Care Leave. It may not be used if group insurance coverage is mandatory (e.g. where the employee does not contribute to the cost of the benefit plan), and is not required if the employee chooses not to apply for Optional Life or Optional Accident Death and Dismemberment insurance.
Please return completed form to your District Benefits Administrator.

Employee's Waiver of Rights

Employee's Last Name	First Name	Initial	District #

Covered Employee

☐ I am currently insured under the PEBT Benefits Program for my District, and

☐ My dependents and I now have coverage under another ❑ Dental ❑ Extended Health Care plan. I understand that we/I have the option of having coverage under more than one plan, but I have chosen to now waive coverage under the PEBT Benefits Program for my District for:

☐ Myself and my dependents ☐ my dependents only for ☐ Dental
☐ Myself and my dependents ☐ my dependents only for ☐ Extended Health

Termination Effective Date (yyyy/mm/dd): _____

Leave of Absence

☐ I am currently insured under the PEBT Benefits Program for my District, and

☐ I am going on a leave of absence/Maternity/Parental/EI Compassionate Care Leave and have chosen to waive coverage under the PEBT Benefits Program for my district during this period of time for the following list of benefits:

Please list benefit coverage to be waived:

_____

Termination Effective Date (yyyy/mm/dd): _____

I understand that if I waive long term disability benefits (if applicable) during my leave and become disabled, the disability will not be covered by the plan and no benefits will be paid at any time. Coverage will not be reinstated until I return to active employment.

I hereby waive the right to the above noted benefits under the PEBT Benefits Program. I understand that proof of insurability may be required if I wish to apply for these benefits at a later date, and that I may be refused coverage at that time.

Plan Member/Employee Signature _____ Date Signed (yyyy/mm/dd) _____

TRANSFER FORM

EXTENDED HEALTH AND DENTAL COVERAGE
DUE TO CANCELLATION OF OTHER COVERAGE

EMPLOYEE ENROLMENT

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

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

School district employee name & employee number:

_____

Name of Benefit Holder of terminating plan: _____

Name of persons terminating from plan: _____

EXTENDED HEALTH

Carrier name & contact phone # _____

Plan group #: _____

ID #: _____

Termination date: _____

DENTAL

Carrier name & contact phone # _____

Plan group #: _____

ID #: _____

Termination date: _____

Name of Employer or Plan Holder: _____

Signature of Plan Administrator: _____ Date: _____

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

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

PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

STATEMENT OF HEALTH

Complete these 4 pages 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)
	Greater Victoria School Distrcit 61		

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 $ _____ (SD61 Optional Life only)
☐ Extended health care
☐ Dental (SD61 will have a $250 Expense Claim Limit)
☐ Short-term disability $ N/A
☐ Long-term disability $ N/A
☐ Critical illness $ N/A
☐ Member Optional Life $ _____
☐ Spouse Optional Life $ _____
☐ Member Optional Critical Illness $ N/A
☐ Spouse Optional Critical Illness $ N/A

PART 2 — APPLICANT INFORMATION

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

Dependent(s) information

Dependent 1

Legal first name	Middle initial	Last name	Birthdate (mm-dd-yyyy)	Gender* ☐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) _____	☐ Yes ☐ No	☐ Yes ☐ No

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 _____

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	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

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**	Date (mm-dd-yyyy)
Spouse signature **X**	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

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.

Greater VICTORIA School District

OVERAGE DEPENDENT STUDENTS

AGE RESTRICTIONS FOR DEPENDENTS

Extended Health and Dental have age restrictions for dependent children. Once a dependent reaches the age limit, the carrier will forward a form to determine if the dependent can remain on coverage. If the dependent is attending a recognized school, college or university, is not in a common-law relationship or marriage and is financially dependent on the parent(s), the dependent may be covered as an "overage" dependent until the age listed below.

The following are the age restrictions for medical, extended health and dental:

	Dependent to age:	Overage dependent to age:
Extended Health (PBC)	**21**	**25**
Dental (PBC)	**21**	**25**

CONTINUATION OF COVERAGE FOR OVERAGE DEPENDENT

Extended Health and Dental (PBC)
When the dependent reaches age 21, we will forward a student confirmation form to determine the eligibility of the dependent. If the dependent is eligible, forms must be completed and returned to the Payroll & Benefits Office. If forms are not received by the requested date, coverage will be cancelled on the last day of the child's birth month. Dependents needing individual coverage, should contact PBC directly.

Once a dependent is set up for coverage as an overage dependent, we will forward forms on an annual basis verifying eligibility. To avoid a break in coverage or loss of coverage, it is very important that the forms are completed in full and returned to the Payroll & Benefits office immediately.

January 2024