Greater VICTORIA School District

NEW ENROLLMENT

BENEFITS CONTROL /WAIVER FORM – CUPE

You must complete and return this form together with your benefit 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: _____ Employee #: _____ School/Location: _____

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

If you are a late applicant a statement of health form will also be required and participation will be decided by the medical underwriting process of the insurance carrier(s).

Enrollment Checklist:

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

☐ I have read and understood the CUPE BENEFITS information, FAQs - including Summer Premium Calculations (found: https://www.sd61.bc.ca/payroll-and-benefits-947/ or https://www.sd61.bc.ca/payroll-and-benefits-382/)

☐ **Extended Health Care** (PBC Policy 53748 or 53724) **pages 2 & 3 required.**

☐ I wish to opt out of **Extended Health Care** (PBC Policy 53748 or 53724) **include page 5**

- Coverage can be waived only if the employee has other Extended Health Care coverage (by spouse or another plan). **Please complete Part 4, Waiver of Benefits, on the attached Enrollment Form**

☐ I want to enroll in Dental (PBC Policy 53748 or 53724) **pages 2 & 3 required**

☐ I wish to opt out of Dental (PBC Policy 53748 or 53724) **include page 5**

- Coverage can be waived only if the employee has other Dental coverage (by spouse or another plan). **Please complete Part 4, Waiver of Benefits, on the attached Enrollment Form**

✓ **Basic Life**** (PBC Policy 53748 or 53724) - **coverage is compulsory; pages 2 & 3 required**
✓ **Basic AD&D**** (AIG Policy BSC9104906) - **coverage is compulsory; pages 2 & 3 required**

☐ **Pre-Authorized Debit Agreement (PAD) signed page 4 required.**

- I understand that when I am not in receipt of pay, premiums will be collected via PAD.

Additional Optional coverage is Available with forms found here: https://www.pebt.ca/pebt-program-benefits/forms/ :

☐ Optional Life (PBC Policy 53748) ☐ Optional AD&D (AIG Policy PAI9104940)

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.

Enrolment Form

COMPLETE THIS FORM FOR THE ADDITION OF A NEW PLAN MEMBER

This form is to be completed on the date of hire for new employees. Keep the original on file, as it will be required by the insurer if there is a a future death or disability claim.

- Section 1 to be fully completed by Plan Sponsor/Employer
- **Sections 2 - 6 to be fully completed by Plan Member/Employee**
- **Return ORIGINAL to your School District Benefits Administrator**

This Enrolment Form complies with the requirements of the Insurers for the PEBT Benefits Program and the information they require to underwrite and administer the benefits plans that are made available

○ New Applicant ○ Reinstatement

1 Plan Sponsor/Employer Information — OFFICE USE ONLY

District	District ID Number	Class	Division
Greater Victoria School District 61	61	3	2

Cost Centre (If applicable)	Employee Hire/Rehire Date	Employee Effective Date	ID Number
	Y Y Y Y / M M / D D	Y Y Y Y / M M / D D	000

Occupation/Position	Earnings Per ___	Policy/Group Contract Numbers	Hours Worked/Week
	$		

Employment Type	Employment Status	Waiting Period (If applicable)
◉ Full-Time ○ Part-Time ○ Seasonal/Contract ○ Other:	◉ Regular ○ Temporary	

2 Plan Member/Employee Information — EMPLOYEE PLEASE COMPLETE PART 2 - 6

Last Name	First Name	Middle Initial

Marital Status

○ Single ○ Married ○ Seperated ○ Widowed ○ Divorced | Civil Union ○ Common-Law*

* Date Of Cohabitation For Common-Law: Y Y Y Y / M M / D D

Mailing Address	E-mail Address	Gender
		○ M - Male ○ X - Another Gender ○ F - Female ○ U - Prefer Not to Disclose

City	Province	Postal Code	Provincial Health Plan Number (Care Card)	Date of Birth
				Y Y Y Y / M M / D D

3 Plan Member/Employee Coverage and Family Information

Please list all of your eligible dependents, even if you select single coverage

Do you have a spouse and/or dependent(s)?	Required Health Coverage	Health Effective Date
○ Yes ○ No	○ Single ○ Couple ○ Family	

Do you have a spouse and/or dependent(s)?	Required Dental Coverage	Dental Effective Date
○ Yes ○ No	○ Single ○ Couple ○ Family	

Spouse's Surname	Spouse's First Name	Spouse's Date of Birth	Gender
		Y Y Y Y / M M / D D	○ M - Male ○ X - Another Gender ○ F - Female ○ U - Prefer Not to Disclose

Does your spouse have benefits through an employer plan?	Employment Type	If yes, please provide policy #, effective date and ID:
○ Yes ○ No	○ Full-Time ○ Part-Time ○ Retiree	

Please indicate your spouse's coverage:

Health:	Dental:
○ Single ○ Couple ○ Family	○ Single ○ Couple ○ Family

Child's full name (last, first)	Date of Birth	Gender	Student **	Disabled ***
	Y Y Y Y / M M / D D	○ M - Male ○ X - Another Gender ○ F - Female ◉ U - Prefer Not to Disclose	○ Yes ○ No	○ Yes ○ No

** Provide name of school and student number of child if over 21 and studying full time

*** If child is overage and a person with a disability, state nature of disability and attach a completed PBC Disabled Dependent Application Form. Please contact your School District Benefits Administrator to confirm your district's dependent child eligibility provision.

Child's full name (last, first)	Date of Birth	Gender	Student **	Disabled ***
	Y Y Y Y / M M / D D	○ M - Male ○ X - Another ○ F - Female ◉ U - Prefer Not to Disclose	○ Yes ○ No	○ Yes ○ No

** Provide name of school and student number of child if over 21 and studying full time

*** If child is overage and a person with a disability, state nature of disability and attach a completed PBC Disabled Dependent Application Form. Please contact your School District Benefits Administrator to confirm your district's dependent child eligibility provision.

Child's full name (last, first)	Date of Birth	Gender	Student **	Disabled ***
	Y Y Y Y / M M / D D	○ M - Male ○ X - Another ○ F - Female ◉ U - Prefer Not to Disclose	○ Yes ○ No	○ Yes ○ No

** Provide name of school and student number of child if over 21 and studying full time

*** If child is overage and a person with a disability, state nature of disability and attach a completed PBC Disabled Dependent Application Form. Please contact your School District Benefits Administrator to confirm your district's dependent child eligibility provision.

To be eligible for benefits coverage, your dependent children must meet the dependent child definition outlined on the PEBT website. Disabled dependents may be eligible for benefits coverage if they became disabled before the limiting age outlined on the PEBT website and are completely dependent on you for financial support. Eligible dependents may vary depending on the benefit plan. Check with your School District Benefits Administrator for further information.

4 Waiver of Benefits

List the names of individuals for which coverage is being waived

If you waive health and/or dental coverage and later lose coverage through another plan, you may apply for benefits under this plan within 31 days. Otherwise you and/or your dependents may be required to provide proof of insurability, and your benefits may be limited or denied under this plan.

If you or your dependents are presently covered for health and/or dental benefits under another benefits plan you may be able to waive coverage for such benefit(s) under this plan.

I waive coverage for myself and my dependents under :

◯ Health ◯ Dental

I waive coverage for my dependents under:

◯ Health ◯ Dental

5 Plan Member/Employee Beneficiary Information

YOU MUST DESIGNATE A BENFICIARY

If you designate a beneficiary who is:

(a) under 18 years of age, or
(b) mentally incapacitated

you should also designate a Trustee for that beneficiary. If this situation applies to you or you have concerns about your named beneficiary's legal status, please consult a legal advisor for further details.

Original beneficiary information will be kept by your Plan Sponsor/Employer.

Name your beneficiary(ies)

Beneficiary's Last Name		Beneficiary's First Name
Relationship to Plan Member	Percent allocated Basic/Optional Life %	Percent allocated Basic AD&D %
Beneficiary's Last Name		Beneficiary's First Name
Relationship to Plan Member	Percent allocated Basic/Optional Life %	Percent allocated Basic AD&D %
Beneficiary's Last Name		Beneficiary's First Name
Relationship to Plan Member	Percent allocated Basic/Optional Life %	Percent allocated Basic AD&D %

I appoint _____ as Trustee to receive any amount designated to a beneficiary who is under the age of 18 or mentally incapacitated.

6 Plan Member/Employee Declaration

I consent to the collection, use, and disclosure of my personal information by my Plan Sponsor/Employer or the administrator, an insurance company, or any other person or organization having any relevant information about me (collectively "the Parties") who require this information for the purpose of administering my group benefits under the plan.

I authorize the Parties to obtain and exchange between them, any personal information about me, my spouse, and my dependent children for the purpose of determining benefit entitlements, and for record keeping, file identification, reporting, underwriting, procurement of health information, claims adjudication and resolution, program management, administration of the plan and other benefits administration services provided from time to time.

Plan Member/Employee Signature

Date Signed (yyyy/mm/dd)

PLEASE RETURN PAGES 1-4 (and 5 if applicable to you) to your SD61 Benefits Specialist using both of the methods below:

1) **email PDF to benefits@sd61.bc.ca**
2) **Send ORIGINAL via mail or district mail** to your School District Benefits Administrator as it will be required by the insurer if there is a a future death or disability claim.

Please complete ·Pre-Authorized Debit (PAD) Plan Agreement Below

1/We authorize THE BOARD OF EDUCATION SCHOOL DISTRICT 61 (GREATER VICTORIA), and the financial institution designated (or any other financial institution 1/we may authorize at any time) to begin deductions as per my/our instructions for regular monthly recurring payments and/or one-time payments from time to time, for payment of all charges arising under my/our THE BOARD OF EDUCATION SCHOOL DISTRICT 61 (GREATER VICTORIA) Regular payments for the full amount of services delivered will be debited to my/our specified account on the last debit date of each month (see attached schedule). THE BOARD OF EDUCATION SCHOOL DISTRICT 61 (GREATER VICTORIA) will provide 10 days written notice of the amount of each regular debit. THE BOARD OF EDUCATION SCHOOL DISTRICT 61 (GREATER VICTORIA) will obtain my/our authorization for any other one-time or sporadic debits.

This authority is to remain in effect until THE BOARD OF EDUCATION SCHOOL DISTRICT 61 (GREATER VICTORIA) has received written notification from me/us of its change or termination. This notification must be received at least (10) ten business days before the next debit is scheduled at the address provided below. 1/We may obtain a sample cancellation form, or more information on my/our right to cancel a PAD Agreement at my/our financial institution or by visiting www.cdnpay.ca.

THE BOARD OF EDUCATION SCHOOL DISTRICT 61 (GREATER VICTORIA) may not assign this authorization, whether directly or indirectly, by operation of law, change of control or otherwise, without providing at least 10 days prior written notice to me/us.

1/We has certain recourse rights if any debit does not comply with this agreement. For example, 1/we have the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. To obtain a form for a Reimbursement Claim, or for more information on my/our recourse rights, 1/we may contact my/our financial institution or visit www.cdnpay.ca.

Type of Service: Personal

PLEASE PRINT **DATE:**_____

Name: _____

Address: _____

City/Town:_____ Province:_____ Postal Code:_____

Phone Number (Bus):_____ (Res):_____

Financial Institution {FI):____AS ON FILE IN THE SCHOOL DISTRICT PAYROLL SYSTEM_____

Fl Account Number: N/A_____ Fl Transit Number: N/A_____

Address:_____N/A_____ _____

City/Town:_____N/A_____ Province:_____N/A_____ Postal Code:_____N/A_____

Authorized Signature(s):._____

The Board of Education School District 61 (Greater Victoria)

For all benefit inquiries, please contact the Payroll & Benefits

Office: benefits@sd61.bc.ca or (250) 475-4201.

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) _____