Greater VICTORIA School District

NEW ENROLLMENT or REINSATEMENT

TTOC DENTAL and EXTENDED HEALTH

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: _____ Employee #: _____

Applications must be submitted in a timely manner as carrier deadlines could affect your eligibility. Benefit forms submitted after your effective date will be backdated and premiums will be adjusted accordingly.

Enrollment Checklist

- ☐ I have read the TTOC FAQ (Found at: https://www.sd61.bc.ca/payroll-and-benefits-gvta/)
- ☐ I want TTOC Dental (PBC Policy 20061) (BCPSEA Group Enrollment Form completed and attached)
- ☐ I want TTOC EHC (PBC Policy 20061) (BCPSEA Group Enrollment Form completed and attached)
- ☐ I understand that when I am not in receipt of pay, premiums will be collected via pre-authorized debit agreement (PAD form completed and attached)
- ☐ This is a LATE application (I understand there will be a dental expense restriction for the first 12 months of coverage for late applications and that PBC will determine my eligibility for EHC)
- ☐ I or my dependents do not need 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 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.

Only complete this form if you have a Common Law Spouse, this form is not applicable for married couples

BRITISH COLUMBIA PUBLIC SCHOOL EMPLOYERS' ASSOCIATION
SOLUTIONS AT WORK

Please return completed form to your District Benefits Administrator.

Common Law Spouse Declaration

Employee Common Law Spouse Declaration

Employee's Last Name	First Name	Initial	District #
			61

Common law spouse name: _____

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 (mm/dd/yyyy) _____

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)
Street Address	E-mail Address		Birthdate (MM/DD/YY)	Sex ☐M ☐F	Family Status ☐Single ☐Couple ☐Family
City	Province	Postal Code	**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.
						☐ Health ☐ Dental	
						☐ Health ☐ Dental	
						☐ Health ☐ Dental	
						☐ Health ☐ Dental	

Part 2: Spousal or Other Coverage

Are you or your dependents covered for extended health and/or dental benefits by another	Benefit	Name of Carrier/Policy #	Effective Date	ID Number	Coverage
☐ No ☐ Yes (specify)	Dental				☐ Single ☐ Couple ☐ Family
	Health				☐ 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	N/A	N/A %	N/A	N/A	☐ Revocable ☐ Irrevocable
APPLICABLE FOR TTOCs	N/A	N/A %	N/A	N/A	☐ Revocable ☐ Irrevocable
N/A	N/A	N/A %	N/A	N/A	☐ Revocable ☐ Irrevocable
N/A	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 _____ Date Signed (MM/DD/YY) _____

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	11	11

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

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

I/We authorize THE BOARD OF EDUCATION SCHOOL DISTRICT 61 (GREATER VICTORIA), and the financial institution designated (or any other financial institution I/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 pay of each month (Note: for May and June where it will be every pay to cover for summer months' benefits for Teachers, TTOCs, and ASAs)**. 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. I/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.

I/We has certain recourse rights if any debit does not comply with this agreement. For example, I/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, I/we may contact my/our financial institution or visit www.cdnpay.ca.

Type of Service: Personal

Employee Number:_____

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:_____

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

Authorized Signature(s):._____

The Board of Education School District 61 (Greater Victoria)
For all benefit inquiries, please contact Benefits Specialist
at the Payroll & Benefits Office: benefits@sd61.bc.ca

Only complete this form if you do not need/want EHC/Dental coverage.
If you want coverage later you may be considered a late applicant.

BRITISH COLUMBIA PUBLIC SCHOOL EMPLOYERS' ASSOCIATION
SOLUTIONS AT WORK

Waiver of Coverage

Part 1: Employee Information

Employee's Last Name	First Name	Initial	District #	Employee ID#	Employee Group
			61		TTOC

Part 2: Waiver of Coverage

Before you sign this form, read the online benefit information available to you at www.bcpseabenefits.ca or ask your employer to explain the benefits to you. You should fully understand all the benefits and plan rules before waiving your coverage.

Section A – Waiver certified by employer (Employer Signature Required)

I understand the benefits available to me under the BCPSEA Buying Group for my District and acknowledge that I have been given an opportunity to apply for these benefits, and

I do not want coverage for the following: ❑ Dental ❑ Extended Health benefits for:

❑ Myself and my dependents ❑ My dependents only

Employer – I hereby certify that: minimum participation requirements, as stipulated in the contract, have been met; this plan requires employees/employers to contribute to the cost of coverage; benefit coverage is not a condition of employment.

Do not sign here:
Employer Signature_____ Date Signed_____

Section B – Waiver due to coverage under another plan

☐ My dependents and I have benefits under another plan, as indicated in Part 3 of my BCPSEA Enrolment form. I understand that we/I have the option of having coverage under more than one plan, but I have chosen to waive coverage under the BCPSEA Buying Group for:

❑ Myself and my dependents ❑ my dependents only for ❑ Dental; Policy Number#_____

❑ Myself and my dependents ❑ my dependents only for ❑ Extended Health; Policy Number#_____

Termination Date:_____

If the other plan terminates, I understand that there are time limits for applying for coverage. If I apply late, or if I apply while the other plan is still active, I understand that dental coverage may be restricted to $250 per person for the first year, and/or my dependents and I will have to provide evidence of good health, and the insurer may decline to cover me or my dependents.

Section C – Waiver due to leave of absence

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

Please list benefit coverage to be waived:

_____

Termination Date:_____

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.

Part 3: Employee Signature

I have been offered the opportunity to participate in the BCPSEA Buying Group plan. I have carefully studied the benefits and the plan rules, and I understand that if I apply at a later date for any benefit(s) that I am now waiving, as explained above, dental coverage may be restricted to $250 per person for the first year of coverage, and/or that I will be required to prove, at my own expense, that I and my dependents are in good health. My insurer reserves the right to refuse my application if my health or my dependent's health is not considered satisfactory.

Employee Signature_____ Date Signed_____