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: _____ Employee #: _____

Applications must be submitted within31 days and not more than 4 months from your eligibility date. 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

- ☐ I have read the FAQ and Manulife Brochure (Found at: https://www.sd61.bc.ca/payroll-and-benefits-gvta/)
- ☐ I want Extended Health Care (PBC Policy 20061) (BCPSEA Group Enrollment Form completed and attached)
- ☐ 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
- ☐ 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 understand that when I am not in receipt of pay, premiums will be collected via pre-authorized debit agreement (PAD form completed and attached)
- ☐ 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)
- ☐ 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: _____ 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	Employee 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
☐ No ☐ Yes (specify)

Benefit	Name of Carrier/Policy #	Effective Date	ID Number	Coverage
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 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 _____ 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	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.

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: 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 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		Teacher or Allied Specialist

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_____

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

DO NOT FILL IN PART 1 - THIS IS FOR THE EMPLOYER TO COMPLETE

Policy number	Name of company/organization	Member ID number	Date of hire/rehire (mm-dd-yyyy)
20061	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 $ _____
☒ Extended health care
☐ Dental (N/A for SD61; Expense Limit of $250 for first 12 mo.)
☐ 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

PUT YOUR INFORMATION HERE

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

THIS IS WHERE YOU ADD YOUR SPOUSE AND/OR CHILDREN

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.

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): _____

Province of residence: BC Date of birth (dd/mmm/yyyy): _____

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

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

5 Trustee appointment

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

I appoint _____ 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 _____ Date signed (dd/mmm/yyyy) _____

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

Manulife assumes no responsibility for the validity or sufficiency of the content provided by you. The items 'you' and 'yours' refer to the plan member, the term "Plan Sponsor" refers to the entity that offers the group benefits plan, such as an employer.

What is the purpose of a beneficiary?

If you intend for some or all of your death benefit to go to specific individuals, it is important to make sure that you plan ahead and select those beneficiaries. Having an up-to-date beneficiary designation will make this possible by listing your primary and contingent beneficiaries and intended allocations.

Beneficiary: the person, people or entity who will receive any death benefit from the basic or optional coverage you have selected through your group benefits plan that becomes payable upon your death. Basic and optional beneficiaries may differ.

Types of beneficiary – Primary vs. Contingent

Primary: the person, people or entity you choose to receive the death benefits. If you choose more than one beneficiary, you will need to indicate what percentage of the benefit you would like each person to receive. When multiple primary beneficiaries are named, the total of the percentages allocated to each primary beneficiary must add up to 100%.

Contingent: the person, people or entity you designate to receive the death benefits if all of the primary beneficiaries die before you. If you select more than one contingent beneficiary, the benefit will be split evenly between the contingent beneficiaries.

What happens to the death benefit when. . .

The primary beneficiary dies before you and no contingent beneficiary is named.	The death benefit will be paid to your estate.
The primary beneficiary dies before you, but there is a contingent beneficiary(ies) designated.	The benefit will be paid to the contingent beneficiary(ies).
You assign two primary beneficiaries, and one beneficiary dies before you, and you have not updated your beneficiary form information.	The entire death benefit that would have been paid to the deceased beneficiary will be paid to the surviving primary beneficiary.

Irrevocable vs. Revocable

Irrevocable: the beneficiary you choose cannot be changed without the written permission of that individual.
For example, if you choose your spouse or partner to be the designated beneficiary and you end up separating, you will not be able to change the beneficiary designation without a completed release form from them.

In Quebec, naming your spouse (must be a civil union) as a beneficiary automatically means that he/she is an irrevocable beneficiary, unless you specify otherwise or divorce.

Revocable: a revocable beneficiary means that the beneficiary you choose can be changed at any time without the permission of that individual.
For example, if you choose your spouse or partner to be the designated beneficiary and you end up separating, you can then change that beneficiary designation without asking for that person's permission.

Naming a minor as a beneficiary

If a benefit becomes payable to a minor who is named as a primary or contingent beneficiary, the benefit can only be paid on behalf of the minor to a trustee or guardian for property, otherwise it will be paid into court to be held until the beneficiary has reached the age of majority for your specific province. It is important therefore, if you are choosing a beneficiary who is a minor at the time of the designation to also name a trustee.

If you are a Quebec resident, the parents are considered tutors of their child.

If a minor has been designated as an irrevocable beneficiary, the policy is automatically frozen until the beneficiary has reached the age of majority for your specific province. A parent, guardian or trustee cannot consent to a beneficiary change on behalf of a minor.

Minor: a person named as a beneficiary who is under the age of majority for your specific province.

Trustee: a person appointed by you to hold the minor's proceeds in trust until the minor reaches the age of majority for your specific province.

Tutor: a tutor acts like a trustee.

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	**Annual earnings**
61	**$**

Plan sponsor	Eligibility date (dd/mmm/yyyy)
BCTF/BCSTA Group Life Plan	

Plan administrator name	Phone number	Email address
Benefits Specialist	(250 475-4149	benefits@sd61.bc.ca

Plan member's name (last, first and middle initial)	Date of birth (dd/mmm/yyyy)

Language preference/Langue préférée	Sex*	Province of residence
◯ English/Anglais ◯ French/Français	◯ Male ◯ Female ◯ Non-binary	BC

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 $ 0.00
- 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)

Occupation

Sex* ◯ Male ◯ Female ◯ Non-binary

Date of birth (dd/mmm/yyyy)

Home phone number ( )

Business phone number ( )

Plan member's address (number, street, apartment)

City

Province

Postal code

Height _____ m _____ cm _____ ft _____ 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

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 _____ cm _____ ft _____ 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* ◯ Male ◯ Female ◯ Non-binary | Date of birth (dd/mmm/yyyy) | Height ________ m ________ cm ________ ft ________ in | Weight ◯ 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? ◯ kg ◯ lb | Was this a gain or a loss? | Reason

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* ◯ Male ◯ Female ◯ Non-binary | Date of birth (dd/mmm/yyyy) | Height ________ m ________ cm ________ ft ________ in | Weight ◯ 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? ◯ kg ◯ lb | Was this a gain or a loss? | Reason

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* ◯ Male ◯ Female ◯ Non-binary | Date of birth (dd/mmm/yyyy) | Height ________ m ________ cm ________ ft ________ in | Weight ◯ 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? ◯ kg ◯ lb | Was this a gain or a loss? | Reason

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

5 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				
☑ 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)

Signature of plan member	Date signed (dd/mmm/yyyy)
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.

Manulife

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

Group Benefits
Refusal of All Coverage

Instructions
Section 1 - General information
Section 2 - Certification and authorization
Please print all answers.

1 General information

Plan contract number(s): 121260 (A)

Plan sponsor name: BCTF/BCSTA Group Life Plan

Plan member name (first, middle initial, last)

Plan administrator name: Benefits Specialist

Plan administrator telephone number: (250) 475-4149

Plan administrator email: benefits@sd61.bc.ca

Comments

2 Certification and authorization

PLEASE NOTE THAT YOU MAY REFUSE COVERAGE **ONLY IF** PARTICIPATION IN YOUR PLAN IS **NOT MANDATORY.**

I hereby certify that I have been given the opportunity to apply for coverage under the Group Benefits plan issued, or to be issued, to my plan sponsor by Manulife. The benefits of the plan have been explained to me and I have elected to decline such coverage for myself and my eligible dependents (if applicable).

I understand if I elect to apply for coverage at a later date, I may be required to wait until there is a qualifying event for which I will then be eligible for enrolment. At such time, I understand I must apply in writing and may be asked to provide Manulife, at my own expense, evidence of insurability for myself and my eligible dependents (if applicable). **I further understand** that Manulife reserves the right to refuse such an application. **I acknowledge**, if coverage is approved, Dental benefits (if any) will be limited during the first 12 months of coverage.

Please sign and date here.

Plan member signature

Date signed (dd/mmm/yyyy)

3 Mailing instructions

Please send the completed form to your plan administrator.

PRINT