School District No. 54 (BULKLEY VALLEY)
"To empower all learners to live the challenges of a diverse and changing world."

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# CUPE - Important Details to Know About Your Benefits

| | |
|---|---|
| **Enrolment** | Once you pass your 45 day probation, the payroll administrator will enrol you in benefits and will send you your ID card.<br><br>If you do not complete and sign the PEBT benefits enrolment form within **four months** of the Initial Eligibility Date, you will be considered a late applicant, and will need to go through the late applicate process. |
| **Eligible Spouses** | Employees can enrol one spouse in benefits at one time. If you have a common law spouse on your Enrolment form, the payroll administrator will send you a **Common Law Spouse Declaration Form** to sign.<br><br>Please note you have **four months** from the date of becoming common law or entering into a marriage to enrol your common law spouse or spouse and any eligible dependents. If enrolled beyond this date, they will be considered a late applicant and will need to go through the late applicant process. |
| **Eligible Dependents** | **Additions:** If you have a new child by birth or gain a new child through Common Law or marriage, please let the Payroll Administrator know. Please note you have **four months** from the birth of the child or common law cohabitation or marriage to enrol your dependent. If enrolled beyond this date, they will be considered a late applicant and will need to go through the late applicant process.<br><br>**Terminations:** If you would like to remove a spouse or dependent, please let the Payroll Administrator know, as soon as possible. |

**For more information about your benefits, and benefit coverage, please visit:** https://www.pebt.ca/school-district/school-district-54/

Public Education BENEFITS TRUST
PEBT
Your benefits, your health

# 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 Disrict 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

| District | | District ID Number | Class | Division |
|---|---|---|---|---|
| | | | | |

| 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 | |

| Occupation/Position | Annual Earnings | 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

| Last Name | First Name | Middle Initial |
|---|---|---|
| | | |

Marital Status

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

* Date of Marriage or Cohabitation For Common-Law: Y Y Y Y / M M / D D

| Mailing Address | Phone Number | 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 | |
| | Required Dental Coverage | Dental Effective Date |
| | ○ Single ○ Couple ○ Family | |

| Spouse's Last Name | 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 Gemder ○ 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 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.

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

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

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.

Trustee Relationship to Plan Member: _____

Trustee Language: ◉ English ◯ French

## 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 _____