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

PO Box 758
Smithers, BC
V0J 2N0
Ph (250) 877-6820
Fax (250) 877-6835

TTOC - Important Details to Know About Benefits

As a TTOC, you are eligible for Extended Health, and Dental benefits, provided the employee (yourself) pay 100% of the cost.

Enrolment	New TTOC's have **four months** to enrol in EHB and dental benefits from the date they were placed on the TTOC list. For example, if placed on the Teacher On Call list effective September 1st, the TTOC would have until December 31st to enrol. If enrolled past the four month window, you will be considered a late applicant and will have to go through the late applicant 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. Please note you have **four months** from the date of becoming common law, or married 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. **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://bcpseabenefits.ca/my-plan/school-district-54/sd54-teachers/

BRITISH COLUMBIA PUBLIC SCHOOL EMPLOYERS' ASSOCIATION

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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

Group Enrolment Form

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.

New applicant ☐ Reinstatement

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)	Gender ☐M – Male ☐ F – Female ☐X – Another Gender ☐U – Prefer Not to Disclose	Marital Status ☐ Single ☐ Married * ☐ Separated ☐ Widowed ☐ Divorced ☐ Civil Union ☐ Common Law* *Date of Marriage or Cohabitation for Common Law (MM/DD/YY):
Required Health Coverage: ☐ Single ☐ Couple ☐ Family			Required Dental Coverage: ☐ 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

First Name	Initial	Last Name (if different from Employee)	Birthdate (MM/DD/YY)	Relationship	Gender (M/F/X/U)	Required Coverage	Provide name of school and student number if child is over 21 and studying full-time. If child is disabled, indicate "disabled" in this section and attach the approved CRA/PWD (Persons with Disability) document. If adding an adopted child, provide date of adoption. If adding a legal ward, provide court document.
						☐ 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)

Employment type: ☐ Full-time ☐ Part-time ☐ Retiree

Benefit	Name of Carrier/Policy #	Effective Date	ID Number	Coverage
Dental				☐ Single ☐ Couple ☐ Family
Health				☐ Single ☐ Couple ☐ Family

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]
					Revocable ☐ Irrevocable
		%			☐ Revocable ☐ Irrevocable
		%			☐ Revocable ☐ Irrevocable
		%			☐ 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) _____

Part 5: For Plan Administrator/Employer Use Only

Name of Employer / Organization	Employment Type	Division	Class[3]
	☐ Full-time Permanent ☐ Part-time Permanent ☐ Temporary ☐ Retiree		

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

Dental	Extended Health	Life ☐ AD&D	☐ STD ☐ LTD
Waiting Period / Effective (MM/DD/YY)	Waiting Period / Effective (MM/DD/YY)	Waiting Period / Effective (MM/DD/YY)	Waiting Period / Effective (MM/DD/YY)

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.