

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 <input type="checkbox"/> M <input type="checkbox"/> F	Family Status <input type="checkbox"/> Single <input type="checkbox"/> Couple <input type="checkbox"/> Family
City	Province	Postal Code	If Extended Health or Dental benefits are Waived, complete this form and attach a Refusal of Coverage form		

Dependents							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.
First Name	Initial	Last Name (if different from Employee)	Birthdate (MM/DD/YY)	Relationship	Gender (M/F)	Required coverage	
						<input type="checkbox"/> Health <input type="checkbox"/> Dental	
						<input type="checkbox"/> Health <input type="checkbox"/> Dental	
						<input type="checkbox"/> Health <input type="checkbox"/> Dental	
						<input type="checkbox"/> Health <input type="checkbox"/> Dental	

Part 2: Spousal or Other Coverage

Are you or your dependents covered for extended health and/or dental benefits by another <input type="checkbox"/> No <input type="checkbox"/> Yes (specify)	Benefit Dental	Name of Carrier/Policy #	Effective Date	ID Number	Coverage <input type="checkbox"/> Single <input type="checkbox"/> Couple <input type="checkbox"/> Family
	Health				<input type="checkbox"/> Single <input type="checkbox"/> Couple <input type="checkbox"/> Family
Employment type: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> 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)	Date of Birth	Share of Proceeds	Relationship	Name of Trustee for Beneficiaries Under 18	Beneficiary Status ²
Last Name First Name Initial	(MM/DD/YY)	%			<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
		%			<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
		%			<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
		%			<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable

Part 4: Personal Data Consent

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 O Full-time Permanent O Part-time Permanent O Temporary O Retiree			Division	Class ³	
Employee's Occupation/Position ⁴			Annual Earnings \$	Date of Hire (MM/DD/YY)	Hours Worked Per Week ⁵		
Dental Waiting Period	Effective (MM/DD/YY)	Extended Health Waiting Period	Effective (MM/DD/YY)	O Life O AD&D Waiting Period	Effective (MM/DD/YY)	O STD O LTD 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.