PUBLIC EDUCATION BENEFITS TRUST

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 future death or disability claim.

- Part 1 to be fully completed by Plan Sponsor/Employer
- Parts 2 - 6 to be fully completed by Plan Member/Employee
- Return ORIGINAL to your District Benefits Administrator

◯ New Applicant ◯ Reinstatement

1 Plan Sponsor/Employer Information

District	District ID Number	Class	Division
Cost Centre (If applicable)	Employee Hire/Rehire Date DD / MM / YYYY	Employee Effective Date DD / MM / YYYY	ID Number
Occupation/Position	Earnings Per ___ $	Policy/Group Contract Numbers	Hours Worked/Week
Employment Type ◯ Full-Time ◯ Part-Time ◯ Seasonal/Contract ◯ Other:		Employment Status ◯ Regular ◯ Temporary	Waiting Period (If applicable)
Health Effective Date		Dental Effective Date	

2 Plan Member/Employee Information

Last Name	First Name		Middle Initial
Marital Status ◯ Single ◯ Married ◯ Separated ◯ Widowed ◯ Divorced ◯ Civil Union ◯ Common-Law*			* Date Of Cohabitation For Common-Law DD / MM / YYYY
Mailing Address	E-mail Address		Gender ◯ M ◯ F
City / Province / Postal Code	Provincial Health Plan Number (Care Card)		Date of Birth DD / MM / YYYY

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)? ◯ Yes ◯ No	Required Health Coverage ◯ Single ◯ Couple ◯ Family		Required Dental Coverage ◯ Single ◯ Couple ◯ Family
Spouse's Surname	Spouse's First Name	Spouse's Date of Birth DD / MM / YYYY	Gender ◯ M ◯ F
Does your spouse have benefits through an employer plan? ◯ Yes ◯ No	If yes, please provide policy #, effective date and ID:		Employment Type ◯ Full-Time ◯ Part-Time ◯ Retiree

Please indicate your spouse's coverage:

Health: ◯ Single ◯ Couple ◯ Family	Dental: ◯ Single ◯ Couple ◯ Family

Child's full name (last, first)	Date of Birth	Gender	Student **	Disabled ***
	DD / MM / YYYY	◯ M ◯ F	◯ Yes ◯ No	◯ Yes ◯ No
** Provide name of school **and student number** of child if over 21 and studying full time		*** If child is handicapped, state nature of disability and attach a completed PBC Disabled Dependent Application Form		
	DD / MM / YYYY	◯ M ◯ F	◯ Yes ◯ No	◯ Yes ◯ No
** Provide name of school **and student number** of child if over 21 and studying full time		*** If child is handicapped, state nature of disability and attach a completed PBC Disabled Dependent Application Form		
	DD / MM / YYYY	◯ M ◯ F	◯ Yes ◯ No	◯ Yes ◯ No
** Provide name of school **and student number** of child if over 21 and studying full time		*** If child is handicapped, state nature of disability and attach a completed PBC Disabled Dependent Application Form		

To be eligible for benefits coverage, your dependent children may be required to be unmarried, or under a certain age as specified on the PEBT website, and dependent on you for financial support. Disabled dependents may be eligible for benefits coverage if they became disabled before the limiting age, and are completely dependent on you for financial support. Eligible dependents may vary depending on the benefit plan. Check with your Plan Sponsor/ Employer 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 coverace 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/Optional AD&D %
Beneficiary's Last Name		Beneficiary's First Name
Relationship to Plan Member	Percent allocated Basic/Optional Life %	Percent allocated Basic/Optional AD&D %
Beneficiary's Last Name		Beneficiary's First Name
Relationship to Plan Member	Percent allocated Basic/Optional Life %	Percent allocated Basic/Optional AD&D %

I appoint _____ as Trustee to receive any amount designated to a beneficiary who is under the age of 18 or mentally incapacitated.

6 Plan Member/Employee Declaration

I hereby apply for PEBT Benefits Program and authorize any required payroll deductions. I consent to the use of my Social Insurance Number by any insurer or administrator of this plan for record keeping, file identification and reporting purposes. I reserve the right to change my beneficiary designations at any time. I confirm that the information I have provided is true and complete.

If I should receive a settlement from, or a judgment against, a liable third party for wage loss, extended health, or other benefits covered under the PEBT Benefits Plan, I agree to and authorize the third party to reimburse the insurer up to the amount of benefits advanced to me pending such settlement or judgment.

I understand that on the date my insurance becomes effective I must be actively at work. I also understand that on the date the insurance of my dependent(s) becomes effective that they cannot be confined to home or hospital.

Plan Member/Employee Signature

Date Signed