BRITISH COLUMBIA
PUBLIC SCHOOL EMPLOYERS'
ASSOCIATION

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

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 (M/D/Y)**	**Gender**	**Family Status**
				☐ M ☐ F	☐ 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**		

Dependants

First Name	Initial	Last Name (if different from Employee)	Birthdate (M/D/Y)	Relationship	Gender (M/F)	Required coverage	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 dependants covered for extended health and/or dental benefits by another plan?

☐ 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 (M/D/Y)	Share of Proceeds %	Relationship	Name of Trustee for Beneficiaries Under 18	Beneficiary Status[2]
				%			☐ Revocable ☐ Irrevocable
				%			☐ Revocable ☐ Irrevocable
				%			☐ Revocable ☐ Irrevocable
				%			☐ Revocable ☐ Irrevocable

I hereby apply for group insurance benefits under my employer's plan and authorize any required payroll deductions. 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 judgement against, a liable third party for wage loss, extended health, or other benefits covered under my group 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 judgement.

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 dependant(s) becomes effective that they cannot be confined to home or hospital.

I consent to the collection, use, and exchange of my personal information by my Plan Sponsor/Employer or the administrator, an insurance company, and/or others who require information to administer my group benefits. I authorize these parties to obtain and exchange between them, any information about me, my spouse, and my dependent children to determine benefit entitlements, and for record keeping, file identification, reporting, underwriting, procurement of health information, claims adjudication and resolution, program management, 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 share information as it relates to 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 permitting the assessment of the claim and the collection of evidence. 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 (M/D/Y) _____

Please see page 2 for further explanation

Part 4: For Plan Administrator/Employer Use Only			
Name of Employer / Organization	Employment Type ☐ Full-time Permanent ☐ Part-time Permanent ☐ Temporary ☐ Retiree	Division	Class[3]
Employee's Occupation/Position[4]	Annual Earnings $	Date of Hire (M/D/Y)	Hours Worked Per Week [5]

Dental	Extended Health	☐ Life ☐ AD&D	☐ STD ☐ LTD
Waiting Period Effective (M/D/Y)	Waiting Period Effective (M/D/Y)	Waiting Period Effective (M/D/Y)	Waiting Period Effective (M/D/Y)

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).

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[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.