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 □ Reinstateme	nt												
Part 1: Employee and B	asic Insu	rance Informatio	on										
Employee's Last Name First Name			Initial		ID Number ¹				Prov	Provincial Health Plan Number (Care Card)			
Street Address E-mail Address					`			Gender	Fam	nily Status			
								$\square_{\mathrm{M}} \square_{\mathrm{F}}$		Single [Couple [Couple Family	
City Province			Postal Code	If Extended Health or Dental benefattach a Refusal of Coverage form					Vaived, c	omplete th	is form and		
Dependants												number below if	
First Name Initial Last Name		me rent from Employee)	Birthdate (M/D/Y)	Relatio	onship	Gender (M/F)	Required coverage		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								
							□Heal	Health Dental					
Part 2: Spousal or Other	r Covers	70											
Part 2: Spousal or Othe	Benefit	Name of Carrier/Poli	#		Effective	- Dete		ID Number		C			
covered for extended health and/or			су #		Епесич	ve Date		1D Number		Coverage			
dental benefits by another plan? No Yes (specify)	Health									□ Single □ Couple □ Family □ Single □ Couple □ Family			
Employment type:									: — гапшу				
		ne 🗀 rant-unne 🗀 i	xemee										
Part 3: Beneficiary Design		2001	D : 6									le on your death.	
applicable)	iciary for Basic Life/Optional Life/Basic AD&D Insurance (if able)		Date of Birth		re of ceeds	Relationshi	p Nam	Name of Trustee for Benefici		nder 18	Beneficiary Status ²		
Last Name	First Name Initial		(M/D/Y)		%							п	
											Revocable Irrevocable		
											□ _∞	п	
					%							e □Irrevocable	
					%						Revocab	e	
											Revocab		
I hereby apply for group insur designations at any time. I co					% %		ed payrol	l deductions. I	reserve tl	ne right to	☐ Revocable	e Irrevocable	
	onfirm that at from, or	the information I has judgement against	ave providest, a liable t	ed is tr hird pa	% % thorize aue and courty for w	omplete. vage loss, o	extended	health, or other	r benefits	covered u	Revocable Change my bunder my grounder	e	
designations at any time. I co If I should receive a settlemen to and authorize the third part I understand that on the date i	onfirm that at from, or by to reimb my insuran	the information I has judgement against urse the insurer upoce becomes effecti	nave providents, a liable to the amount	ed is tr hird pa ant of l	% % thorize a ue and courty for we benefits a	omplete. vage loss, o advanced	extended to me per	health, or other	r benefits ement or	covered un judgement	Revocable Revocable change my bunder my grounder.	e	
designations at any time. I co If I should receive a settlemen to and authorize the third part	onfirm that at from, or by to reimb my insuran	the information I has judgement against urse the insurer upoce becomes effecti	nave providents, a liable to the amount	ed is tr hird pa ant of l	% % thorize a ue and courty for we benefits a	omplete. vage loss, o advanced	extended to me per	health, or other	r benefits ement or	covered un judgement	Revocable Revocable change my bunder my grounder.	e	
designations at any time. I co If I should receive a settlemen to and authorize the third part I understand that on the date i	onfirm that It from, or The ty to reimb The ty to reim	the information I has judgement against urse the insurer up to be becomes effect to home or hospital. The properties of my person my group benefits. I sefit entitlements, a magement, and otherity, to share informate to provide the Iron of evidence. I he in given above is true.	al informat authorize t nd for recorder services mation as it	ed is tr hird pa ant of t e active ion by hese pa rd keep provid relates mpanie for gro	% % thorize a ue and courty for wo benefits a dely at wo my Plan arties to boing, file ed from to to the plan to t	omplete. vage loss, of advanced ork. I also Sponsor/I obtain and identificatime to tirlan. In the required befits under	extended to me per understa Employer dexchangtion, repense. I concase of coy the lat my Plan	health, or other nding such settle and that on the of or the adminis- ge between ther orting, underwr firm that I have death, I express ter, with all the Sponsor's/Emp	r benefits ement or late the ir strator, an n, any inf iting, pro- obtained ly authori informati loyer's pla	insurance of insurance or consent from and authen and authen and authen and authen and authen in covered to consent from and authen and authen and authen and authen in authen i	Revocabi Revocabi Revocabi change my b nder my grou f my depend company, a about me, my f health info om my spou oloyer, the po thorizations horize any re	peneficiary ap plan, I agree ant(s) becomes and/or others y spouse, and branation, claims se and any blicyholder, the permitting the equired	
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Part 4: For Plan Administrator/Employer Use Only												
Name of Employer / Organization			Employment Type					ion	Class ³			
□ Full-time Permanent □ Part-time Permanent □ Temporary □ Retiree												
Employee's Occupation/Position ⁴				nnual Earnings	Date of Hire (M/D/Y)			Hours Worked Per Week ⁵				
			Ψ									
	Extended Health			□Life □AD&D		\square_{ST}	TD 🗖 L	TD				
Effective (M/D/Y)	Waiting Period	Effective (M/D/Y)		Waiting Period	Effective (M/D/Y)	Waitii	ng Perio	d Effe	ective (M/D/Y)			
1	ization sition ⁴	ization Sition Extended Health	Employn Full-t sition Extended Health Waiting Period Effective	Employment Full-time sition Extended Health Effective (M/D/Y) Waiting Period Employment A \$	Employment Type Full-time Permanent	Employment Type Full-time Permanent	Employment Type Full-time Permanent Part-time Permanent Temporary Retiree	Employment Type Full-time Permanent Part-time Permanent Temporary Retiree	Employment Type Full-time Permanent Part-time Permanent Temporary Retiree			

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).

- 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)*

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:

^{*}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.