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 origional on file, as it will be required by the insurer if there is a a future death or disability claim.

- Section 1 to be fully completed by Plan Sponsor/Employer
- Sections 2 - 6 to be fully completed by Plan Member/Employee
- Return ORIGINAL to you Disrict Benefits Administrator

○ New Applicant ○ Reinstatement

1 Plan Sponsor/Employer Information

District	District ID Number	Class	Division
School District No 52 (Prince Rupert)			52-12

Cost Centre (If applicable)	Employee Hire/Rehire Date	Employee Effective Date	ID Number
	YYYY / MM / DD	YYYY / MM / DD	

Occupation/Position	Earnings Per ___	Policy/Group Contract Numbers	Hours Worked/Week
	$	53754	

Employment Type	Employment Status	Waiting Period (If applicable)
○ Full-Time ⊗ Part-Time ○ Seasonal/Contract ○ Other:	○ Regular ○ Temporary	30 days - Dental

2 Plan Member/Employee Information

Last Name	First Name	Middle Initial

Marital Status	* Date Of Cohabitation For Common-Law
○ Single ○ Married ○ Seperated ○ Widowed ○ Divorced ○ Civil Union ○ Common-Law*	YYYY / MM / DD

Mailing Address	E-mail Address	Gender
		○ M ○ F

City	Province	Postal Code	Provincial Health Plan Number (Care Card)	Date of Birth
				YYYY / MM / DD

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)?	Required Health Coverage	Health Effective Date
○ Yes ○ No	○ Single ○ Couple ○ Family	

Do you have a spouse and/or dependent(s)?	Required Dental Coverage	Dental Effective Date
○ Yes ○ No	○ Single ○ Couple ○ Family	

Spouse's Surname	Spouse's First Name	Spouse's Date of Birth	Gender
		YYYY / MM / DD	○ M ○ F

Does your spouse have benefits through an employer plan?	Employment Type	If yes, please provide policy #, effective date and ID:
○ Yes ○ No	○ Full-Time ○ Part-Time ○ Retiree	

Please indicate your spouse's coverage:

Health:	Dental:
○ Single ○ Couple ○ Family	○ Single ○ Couple ○ Family

Child's full name (last, first)	Date of Birth	Gender	Student **	Disabled ***
	YYYY / MM / DD	○ 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

Child's full name (last, first)	Date of Birth	Gender	Student **	Disabled ***
	YYYY / MM / DD	○ 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

Child's full name (last, first)	Date of Birth	Gender	Student **	Disabled ***
	YYYY / MM / DD	○ 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, under age 21, or under age 25 if they are a full-time student at a recognized school and dependent on you for financial support. Disabled dependents may be eligible for benefits coverage if they became disabled before the limiting ages above, 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

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Waiver of Coverage

This form must be completed and signed by any employee who decides to waive Extended Health or Dental benefits because they have coverage under a spouse's plan or by any employee wishing to waive coverage while on a Leave of Absence, Maternity, Parental or EI Compassionate Care Leave. It may not be used if group insurance coverage is mandatory (e.g. where the employee does not contribute to the cost of the benefit plan), and is not required if the employee chooses not to apply for Optional Life or Optional Accident Death and Dismemberment insurance.
Please return completed form to your District Benefits Administrator.

Employee's Waiver of Rights

Employee's Last Name	First Name	Initial	District #

New Applicant

- ❑ I understand the benefits available to me under the PEBT Benefits Program for my District and acknowledge that I have been given an opportunity to apply for these benefits, and
  - ❑ My dependents and I have ❑ Dental ❑ Extended Health benefits under another plan, as indicated in Part 3 of my PEBT Enrolment form. I understand that we/I have the option of having coverage under more than one plan, but I have chosen to waive coverage under the PEBT Benefit Program for:

    ❑ Myself and my dependents ❑ my dependents only for ❑ Dental
    ❑ Myself and my dependents ❑ my dependents only for ❑ Extended Health

Covered Employee

- ❑ I am currently insured under the PEBT Benefits Program for my District, and
  - ❑ My dependents and I now have coverage under another ❑ Dental ❑ Extended Health Care plan. I understand that we/I have the option of having coverage under more than one plan, but I have chosen to now waive coverage under the PEBT Benefits Program for my District for:

    ❑ Myself and my dependents ❑ my dependents only for ❑ Dental
    ❑ Myself and my dependents ❑ my dependents only for ❑ Extended Health

    Termination Effective Date (yyyy/mm/dd): _____

  - ❑ I am going on a leave of absence/Maternity/Parental/EI Compassionate Care Leave and have chosen to waive coverage under the PEBT Benefits Program for my district during this period of time for the following list of benefits:

Please list benefit coverage to be waived:

_____

I understand that if I waive long term disability benefits (if applicable) during my leave and become disabled, the disability will not be covered by the plan and no benefits will be paid at any time. Coverage will not be reinstated until I return to active employment.

I hereby waive the right to the above noted benefits under the PEBT Benefits Program. I understand that proof of insurability may be required if I wish to apply for these benefits at a later date, and that I may be refused coverage at that time.

Employee Signature _____ Date Signed (yyyy/mm/dd) _____

MANDATORY

PENSION CORPORATION
Municipal Pension Plan

PLAN MEMBER RECORD

Pension Corporation
Employer Data Services
PO Box 9460 Stn Prov Govt
Victoria BC V8W 9V8

Victoria 250-356-9701
Toll-free 1-800-663-8823
Fax 250-953-0419
E-mail EDS.PensionCorp@gems9.gov.bc.ca

04 MPP

ORGANIZATION ID

FILE

TEAM

EMPLOYER INSTRUCTIONS: At month end submit **only** one copy of this form to the Pension Corporation to enrol a new plan member or change a plan member's personal or employment information. Refer to the **Employer Reporting Instructions**, on-line at **pensions.bc.ca/municipal/foremployers.htm**, for information on completing this form. Direct questions and completed forms to Employer Data Services (contact info above).

☐ **NEW**
(New Plan Member at your organization—enter complete information in every field on form.)

☐ **CHANGE**
(Existing Plan Member—complete the REQUIRED BASE DATA section and ONLY the DETAIL DATA field(s) that have CHANGED.)

REQUIRED BASE DATA (Must be entered every time)

PLAN MEMBER'S LAST NAME (Please print) | GIVEN NAME(S) | TITLE | SOCIAL INSURANCE NUMBER

DETAIL DATA (Enter all applicable data when NEW; enter only changed data when CHANGE)

PERSONAL

GENDER ☐ FEMALE ☐ MALE | PREVIOUS SOCIAL INSURANCE NUMBER | EMPLOYEE'S DATE OF BIRTH YYYY MM DD

EMPLOYEE'S PREVIOUS LAST NAME IF CHANGED (Please print) | PREVIOUS GIVEN NAME

EMPLOYMENT

EMPLOYEE GROUP (8 characters) | HIRE DATE YYYY MM DD | CONTRIBUTION START DATE YYYY MM DD 20

ORGANIZATION NAME | BARGAINING UNIT

ADDRESS

Note: All address fields must be completed when any address information is provided.

EMPLOYEE'S MAILING ADDRESS (required at time of enrolment only)

CITY | POSTAL CODE | HOME PHONE

SPOUSE

SPOUSE'S LAST NAME (Current - please print) | GIVEN NAME | SPOUSE'S DATE OF BIRTH YYYY MM DD

COMMENTS

EMPLOYER CONTACT PREPARING THIS FORM

PREPARED BY (Please print) | CONTACT PHONE NUMBER | EXTENSION | DATE REPORT COMPLETED YYYY MM DD 20

DOCUMENTS ATTACHED (if form is mailed)

☐ BIRTH CERTIFICATE (certified copy - not originals) OR ☐ _____ (certified copy)

☐ MARRIAGE CERTIFICATE (certified copy - not originals) OR ☐ _____ (certified copy)

If form is sent electronically, forward certified documents separately. CERTIFIED DOCUMENTS REQUIRE PLAN MEMBER'S NAME AND SOCIAL INSURANCE NUMBER.

Freedom of Information and Protection of Privacy Act—The personal information on this form is collected under the authority of the *Public Sector Pension Plans Act* and will be used by the Pension Corporation to administer the plan member's pension. If you or the plan member have questions about the collection and use of this information, contact the chief executive officer at the above address or by telephone at (250) 387-1002.