BRITISH COLUMBIA
PUBLIC SCHOOL EMPLOYERS'
ASSOCIATION

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 #	Employee Group

New Applicant

❑ I understand the benefits available to me under the BCPSEA Buying Group 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 BCPSEA 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 BCPSEA Buying Group 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 BCPSEA Buying Group 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 BCPSEA Buying Group 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 (mm/dd/yyyy): _____

❑ I am going on a leave of absence/Maternity/Parental/EI Compassionate Care Leave and have chosen to waive coverage under the BCPSEA Buying Group 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 BCPSEA Buying Group. 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 (mm/dd/yyyy) _____