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 Insurance Application

Part 1: Employee & Basic Insurance Information

*** If Extended Health or Dental benefits are waived, complete this form and attach a Refusal of Coverage form.**

Employee's Last Name	First Name	Initial	ID Number		Provincial Health Plan Number (Care Card)
Street Address			Birthdate (M/D/Y)	Gender ❑ M ❑ F	Family Status ❑ Single ❑ Couple ❑ Family
City	Province	Postal Code	Extended Health Coverage Required * ❑ Single ❑ Couple ❑ Family ❑ Waived		Dental Coverage Required * ❑ Single ❑ Couple ❑ Family ❑ Waived

Dependant	First Name	Initial	Last Name (if different from Employee)	Birthdate (M/D/Y)	Relationship	Gender (M/F)	Provide name of school below if child is over 21 and studying full time. If child is disabled, state nature of disability and attach full details.
01 Spouse							
02 1st child							
03 2nd child							
04 3rd child							
05 4th child							

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	Group Number	ID Number	Coverage
	Dental:				❑ Single ❑ Couple ❑ Family
	Health:				❑ Single ❑ Couple ❑ Family

Part 3: Beneficiary Designation & Optional AD&D Insurance

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	Share of Proceeds	Relationship	Name of Trustee for Beneficiaries Under 18
			%		
			%		
			%		
			%		

Optional AD&D Insurance	Type of AD&D Plan	Beneficiary for Employee's Optional AD&D Insurance Last Name	First Name	Initial	Relationship	Name of Trustee for Beneficiaries Under 18
$	❑ Single ❑ Family					

I hereby apply for group insurance benefits under my employer's plan 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 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.

Employee Signature _____ Date Signed (M/D/Y) _____

Part 4: For Plan Administrator / Employer Use Only

Name of Employer / Organization	Division	Class

Employee's Occupation / Position	Earnings $ per	Date of Hire (M/D/Y)	Hours Worked Per Week

Dental Group Number		Health Group Number		❑ Life ❑ STD ❑ LTD Group Number		Division Class	AD&D Group Number	
Waiting Period	Effective (M/D/Y)	Waiting Period	Effective (M/D/Y)	Waiting Period	Effective (M/D/Y)		Waiting Period	Effective (M/D/Y)