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	ent												
Part 1: Employee and Basic Insurance Information													
Employee's Last Name	's Last Name First Name Initial			ID Number ¹				Prov	Provincial Health Plan Number (Care Card)				
Street Address		E-mail Address				te (MM/DD/	YY)	Gender	Fam	Family Status			
								□м □г		□Single □Couple □Family			
City	Province Postal Code				If Extended Health or Dental benefits and attach a Refusal of Coverage for					s are Waived, complete this form			
Dependents First Name Initial Last Name (if different from Employee)			Birthdate (MM/DD/YY)	onship Gender Requ			Required coverage det		Provide name of school and student number below if child is over 21 and studying full time. If child is lisabled, state nature of disability and attach full letails. If adding an adopted child, provide date of doption. If adding a legal ward, provide court				
							☐Health ☐Dental		document.				
							☐ Health ☐ Dental						
							☐Health ☐Dental						
							Heal	th Dental					
Part 2: Spousal or Othe	er Covera	ige											
Are you or your dependents covered for extended health and/or dental benefits by another	Benefit Dental	Name of Carrier/Policy #			Effective Date			_		Coverage Single			
□No □Yes (specify)	Health									Single			
Employment type:	☐Full-ti	me Part-time	Retiree								-	-	
Part 3: Beneficiary Desi	ignation											m verm deeth	
i ait 3. Deficitorary Desi	ignation.				Compl	ete the follo	wing sec	tion to appoint a	beneficiary	y for any be	nefits payable o	in your death.	
Beneficiary for Basic Life/Optional applicable)		AD&D Insurance (if	Date of Birth		re of ceeds	ete the follo Relationshi		tion to appoint a			nefits payable o		
Beneficiary for Basic Life/Optional			Date of Birth (MM/DD/YY)		re of						Beneficiary Sta	utus ²	
Beneficiary for Basic Life/Optional applicable)	Life/Basic A				re of ceeds						Beneficiary Sta		
Beneficiary for Basic Life/Optional applicable)	Life/Basic A				re of ceeds						Beneficiary Sta	utus² ☐ Irrevocable	
Beneficiary for Basic Life/Optional applicable)	Life/Basic A				re of ceeds %						□ Revocable □ Revocable □ Revocable	☐ Irrevocable☐ Irrevocable	
Beneficiary for Basic Life/Optional applicable)	Life/Basic A				re of ceeds % % %						□ Revocable □ Revocable □ Revocable	☐ Irrevocable ☐ Irrevocable ☐ Irrevocable	
Beneficiary for Basic Life/Optional applicable) Last Name	First Name Consent a, use, and rson or or ing my gr / spouse, a underwriti	Initial I disclosure of meganization having benefits und and my dependering, procurement	y personal infig any relevanter the plan. Int children for to f health infe	From Proximate to informate the position of th	% % % with the second s	my Plan S about me Parties to of determ	Sponsore (collecto obtainining b	e of Trustee for Be T/Employer or ctively "the P n and exchang enefit entitler	the adm arties") ge betwe ments, an	ninistrator who requenthem, and for rec	Revocable Revocable Revocable Revocable r, an insuran ire this infor any persona ord keeping	☐ Irrevocable ☐ Irrevocable ☐ Irrevocable ☐ Irrevocable ☐ Irrevocable ☐ cee mation for all, file	
Beneficiary for Basic Life/Optional applicable) Last Name Part 4: Personal Data C I consent to the collection company, or any other per the purpose of administer information about me, my identification, reporting, t	First Name Consent In, use, and rison or or ing my gr 7 spouse, and response, anderwrith ices provided cons	d disclosure of m rganization having the dependent and my dependenting, procurementiated from time to the total my spo	y personal infig any relevanter the plan. In the children for the of time.	From Proximation authors the pormation	% % % ion by remation orize the urpose on, claim	my Plan S about me e Parties to	Sponsor e (colle to obtaining b lication	y/Employer or ctively "the P n and exchangenefit entitler and resolutio	the adm arties") ge betwee ments, ar	ninistrator who requeen them, and for rec	Revocable Revocable Revocable Revocable r, an insuran ire this infor any persona ord keeping gement, adm	☐ Irrevocable	
Part 4: Personal Data C I consent to the collection company, or any other per the purpose of administer information about me, my identification, reporting, to of the plan and other service. I confirm that I have obtain	First Name Consent a, use, and rson or or ing my gr y spouse, a underwrittices providined conserted conserted conserted admin pressly aut	Initial Id disclosure of maganization having benefits und and my dependering, procurement ided from time to the tent from my sponinistration of the thorize my employed.	y personal infing any relevanter the plan. Interchildren for to of health infine time. use and any diplan. byer, the police	Processing	ion by rmation orize the urpose con, claiment childer, the b	my Plan S about me e Parties t of determ ims adjud	Sponsone (colle to obtainining blication r the ag	T/Employer or ctively "the P n and exchangenefit entitler and resolution e of majority,	the admarties") ge betweenents, and, prograto disclessof my es	ninistrator who requenthem, and for recam mana	Revocable Revocable Revocable Revocable Revocable r, an insuran ire this infor any persona ord keeping gement, adm	☐ Irrevocable ☐	
Beneficiary for Basic Life/Optional applicable) Last Name Part 4: Personal Data Company, or any other per the purpose of administer information about me, my identification, reporting, to of the plan and other service. I confirm that I have obtain the Parties as required for In the case of death, I exp	First Name Consent a, use, and rson or or ing my grouse, aunderwrittices providined consected the admit oressly aut do by the laborenefits underenefits under energia undere	Initial Idisclosure of mreganization having benefits und and my dependering, procurement ided from time to the sent from my sponistration of the thorize my emploatter, with all the under my Plan Sp	y personal infig any relevanter the plan. Int children for to f health info time. use and any diplan. byer, the polic information a consor's/Emplo	Procession	ion by remation orize the urpose on, claiment childer, the lathoriza plan an	my Plan S about me e Parties to of determins adjudented denote the control of the	Sponson e (colle to obtaining b lication r the ag ry, heir aired fo ze any i	y/Employer or ctively "the P n and exchangenefit entitler and resolution or liquidator or the procession required dedu	the admarties") ge betweenents, and, programents of my esong of an octions. I	ninistrator who requested them, and for recommendament ose their tate to pry claim(s	Revocable Revocable Revocable Revocable Revocable Revocable r, an insuran ire this infor any persona ord keeping gement, adm personal info ovide the Insulation	☐ Irrevocable ☐	
Part 4: Personal Data C I consent to the collection company, or any other per the purpose of administer information about me, my identification, reporting, to of the plan and other service. I confirm that I have obtain the Parties as required for In the case of death, I expression companies, when required I hereby apply for group to given above is true and companies.	First Name Consent In, use, and rson or or ing my gr It ices providined consect the admit oressly aut do by the laborated by the laborated. A	d disclosure of maganization having and my depender ing, procurement ided from time to sent from my sponsinistration of the thorize my emploatter, with all the noder my Plan Sp A photocopy of the interval of the control of the cont	y personal infig any relevanter the plan. Interchildren for the of time. The plan is a subject to the plan information at the	Procession is Procession is Procession is Procession in Pr	ion by remation orize the urpose on, claiment childer, the lathoriza plan an	my Plan S about me e Parties to of determins adjudented denote the control of the	Sponsor e (colle to obtainining b lication r the agency, heir nired fo ze any r riginal.	y/Employer or ctively "the P n and exchangenefit entitler and resolution or liquidator or the procession required dedu	the admarties") ge betweenents, and not prograte to disclessing of any extensions. I enrolments	ninistrator who requesen them, and for rec am mana ose their tate to pr y claim(s certify that form w	Revocable	Irrevocable Irrevocable Irrevocable Irrevocable Irrevocable Irrevocable ce mation for ll , file uninistration commation to surance mation d by my	

Part 5: For Plan Administrator/Employer Use Only											
Name of Employer / Org		Employment	Employment Type					ion	Class ³		
□Full-t				ll-time Permanent ☐ Part-time Permanent ☐ Temporary ☐ Retiree							
Employee's Occupation/Position ⁴				A	Annual Earnings	Date of Hire (MM/DD/Y		Y)	Hours Worked Per Wee		
				\$							
Dental		Extended Health			□Life □AD&D		\square_{S}	гр 🗖 і	LTD		
Waiting Period	Effective (MM/DD/YY)	Waiting Period	Effective (MM/DD/YY)		Waiting Period	Effective (MM/DD/YY)	Waiti	ng Peri		ective M/DD/YY)	

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.