PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

ENROLLMENT APPLICATION FOR GROUP BENEFITS

Please return completed form to Human Resources, Strand Hall, Room 2170 or email the form to hradmin@sfu.ca

MEMBER — Please complete Parts 2 and 7 of this application and only complete Parts 3 to 6, if applicable.
EMPLOYERS/PLAN ADMINISTRATORS — Please complete Part 1 of this application and only complete Part 6, Section B, if applicable.
Please complete form electronically or print clearly in **INK**. Sign, date and submit your application to your Employer or Plan Administrator as soon as possible.

☐ New member ☐ Reinstatement

PART 1 — EMPLOYER/PLAN ADMINISTRATOR

Policy number	Name of company/organization		Member ID number	
	Simon Fraser University			
Extended Health Care effective date (mm-dd-yyyy)	**Dental Care effective date (mm-dd-yyyy)**		**Life and Disability effective date (mm-dd-yyyy)**	**Other benefit effective date (mm-dd-yyyy)**
Division	**Sub-division (if applicable)**	**Class**	**Section ID (if applicable)**	**Plan Code (if applicable)**
Member's occupation			**Employment type** ☐ Full-time ☐ Part-time ☐ Retired ☐ Hour bank ☐ Other:	
Payroll number (if applicable)	**Date of full-time hire or rehire (mm-dd-yyyy)**		**Member salary** $ _____ ☐ Hourly ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually	**Hours per week**

HSA deposit amount: $ _____ Frequency: ☐ Annual ☐ Monthly

If we have questions, how can we contact you? ☐ Telephone: _____ ☐ Email: hradmin@sfu.ca

PART 2 — MEMBER/DEPENDENT INFORMATION

Legal first name	Preferred name	Middle initial	Last name	Birthdate (mm-dd-yyyy)	Sex ☐ M ☐ F

Street address	City	Province	Postal code

Email address

Please provide the information requested in the table below. List any additional children in *Part 3 – Additional Information* section. Please list all your dependents even if you are waiving coverage.

LEGAL FIRST NAME	PREFERRED NAME	MIDDLE INITIAL	LAST NAME	BIRTHDATE (MM-DD-YYYY)	SEX	RELATIONSHIP TO YOU	FULL TIME STUDENT*	DISABLED DEPENDENT**
Spouse					☐ M ☐ F	☐ Common-Law ☐ Married		
First child					☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No
Second child					☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No
Third child					☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No
Fourth child					☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No

*Complete this section if child is over the maximum age as stated in your Group Benefit Contract and attending school full-time.
**If you have a child with a disability, provide a copy of the notice of approval decision from CRA in response to your disability tax credit certificate application.

Please advise on the following: 1. Is the dependent financially dependent on you? ☐ Yes ☐ No 2. Does the dependent reside with you? ☐ Yes ☐ No
3. Is the dependent married, or has the dependent ever been married? ☐ Yes ☐ No

PART 3 — ADDITIONAL INFORMATION

PART 4 — CO-ORDINATION OF BENEFITS

If you or any of your dependents have coverage under another plan, please indicate the following:

Name of Insurance company	Group Policy Number	ID or certificate number

PART 5 — BENEFICIARY DESIGNATION

If your plan includes Group Life or Accidental Death & Dismemberment insurance, designate at least one beneficiary. If you do not nominate a beneficiary, these benefits will be paid to your estate in the event of your death. If you make an error, sign or initial beside the correction. For residents of the Province of Quebec, the designation of a spouse is irrevocable unless otherwise specified. If share of proceeds for multiple beneficiaries is not indicated, the share will be split evenly between the listed beneficiaries.

☐ Revocable ☐ Irrevocable | I designate the following person(s) to receive any amount due under the group policy upon my death.

Full legal name	Birthdate (mm-dd-yyyy)	Relationship to you	Share of proceeds
			%
			%

Member trustee designation — Complete only if a beneficiary is under age 18

I hereby appoint as trustee to receive from British Columbia Life & Casualty Company any amount which may be due to my beneficiary, while the beneficiary is a minor:

Full legal name	Birthdate (mm-dd-yyyy)	Relationship to you

To appoint a contingent beneficiary(ies) in the event that your primary beneficiary(ies) die before you, complete our Beneficiary Designation Form.

PART 6 — WAIVER OF GROUP BENEFITS (Complete this section if waiving benefits)

The Pacific Blue Cross Extended Health Care (EHC) plan is not the same as coverage under a government health/medical plan in any Province or Territory. If another plan covers you/your dependent(s) for EHC or Dental benefits, you may waive such benefits under this plan. Before you sign this form, read your benefit booklet or ask your employer to explain the benefits to you. You should fully understand all the benefits and plan rules.

SECTION A — Waiver due to coverage under another plan

I choose to waive the benefit(s) below because I am covered by another plan:
☐ Extended Health Care ☐ Dental Care ☐ For myself and my dependents ☐ For my dependents only

If the other plan terminates, I understand that there may be time limits for applying for coverage under this Pacific Blue Cross plan. If I apply late, or if I apply while the other plan is still active, I understand that dental coverage may be restricted to $250 per person for the first year, and/or my dependents and I will have to provide evidence of good health, and Pacific Blue Cross may decline to cover me or my dependents.

SECTION B — Refusal of ALL coverage (available for Non-Mandatory plans only) — Approval required by your employer

☐ I waive all coverage for myself and my dependents

EMPLOYER/PLAN ADMINISTRATOR — I hereby certify that: minimum participation requirements, as stipulated in the contract have been met; this plan requires members/employers to contribute to the cost of coverage; benefit coverage is not a condition of employment.

Employer/Plan administrator's signature	Date (mm-dd-yyyy)
X	

Member signature is required for SECTIONS A and B

I have been offered the opportunity to participate in my employer's benefits plan under the policy number(s) on page 1. I understand that if I apply at a later date for any benefit(s) that I am now waiving, as explained above, dental coverage may be restricted to $250 per person for the first year of coverage, and/or I will be required to prove, at my own expense, that I and my dependents are in good health. Pacific Blue Cross reserves the right to refuse my application if my health or my dependents' health is not considered satisfactory.

Member's signature	Date (mm-dd-yyyy)
X	

PART 7 — MEMBER SIGNATURE

I agree to the conditions of my benefit plan between my employer/plan administrator and Pacific Blue Cross and authorize my employer to deduct the required contributions from my earnings. I confirm that the information I have provided is true and complete.

If I should receive a settlement or a judgement against a liable third party for wage loss or benefits covered under my group plan, I agree to and authorize the third party to reimburse Pacific Blue Cross up to the amount advanced to me pending such settlement or judgement.

I consent to Pacific Blue Cross collecting, using and disclosing my personal information where reasonably necessary for the purposes of my enrollment or coverage under this group plan. I consent to the disclosure of my personal information to agents and representatives of Pacific Blue Cross and other providers/insurers and their agents and representatives for the purposes of assessing and providing benefits coverage. I also consent to the disclosure of my personal information to my employer/plan administrator when required or permitted by law or by contract between Pacific Blue Cross and my employer/plan administrator; and to the retention, use and disclosure of my personal information in accordance with the Pacific Blue Cross privacy policy.

The privacy policy is available online at pac.bluecross.ca or by calling Pacific Blue Cross at 604 419-2000.

Member's signature	Date (mm-dd-yyyy)
X	