Flexible Benefits Program Enrolment/Change Form

British Columbia — BC Public Service — Where ideas work

INSTRUCTIONS:

Initial Enrolment: Please complete all sections of the form and submit to MyHR. Forms must be received no later than 30 days from your date of hire/eligibility or you will receive the default benefits package. Left-over flex credits will be paid out monthly as taxable income.

Updating your Coverage: If you are updating your coverage due to an eligible life event or open enrolment, please complete only those sections where a change is being made and leave the other sections blank EXCEPT if you are allocating flex credits to a Health Spending Account during open enrolment. You must select "elect HSA" and record the annual amount on this form. Your form must be received no later than the applicable deadline (e.g., the Open Enrolment deadline posted on MyHR; 60 days from the date of an eligible life event).

Submit forms for processing through an AskMyHR Online Service Request or by fax or mail:

AskMyHR Online Service Request: www.gov.bc.ca/myhr/contact

Fax: 604-320-4031

Mail: Benefit Service Centre
Block E – 2261 Keating Cross Rd
Saanichton, BC V8M 2A5

Questions?
Please visit MyHR at:
www.gov.bc.ca/myhr/

Section A **Employee Information** You must enrol under your legal name.	**Legal** Name (last name, first name, middle initial)			Employee number
	Home/Mailing address (Street, City Postal Code)			Email address
	Date of birth (yyyy/mm/dd)	Gender (☑) ☐ M ☐ F	Ministry	
Section B **Purpose of Form** (Choose one ☑)	☐ Initial Enrolment	☐ Open Enrolment	☐ Eligible Life Event Event: Date of Event: (yyyy/mm/dd)	☐ Cancel YOUR Benefits Effective Date: (yyyy/mm/dd)

Section C **Dependant Information** You must enrol your dependant(s) under their legal name(s).	**Legal** Name (last name, first name, middle initial)			☐ Add coverage ☐ Cancel coverage
	Date of birth (yyyy/mm/dd)	Gender (☑) ☐ M ☐ F	Relationship to you? ☐ Spouse	☐ Dependent Child[1] ☐ Full-time Student[2] (19-24yrs) ☐ Disabled Dependent Child[3]
	Additional Information: (see notes below)			
	Legal Name (last name, first name, middle initial)			☐ Add coverage ☐ Cancel coverage
	Date of birth (yyyy/mm/dd)	Gender (☑) ☐ M ☐ F	Relationship to you? ☐ Spouse	☐ Dependent Child[1] ☐ Full-time Student[2] (19-24yrs) ☐ Disabled Dependent Child[3]
	Additional Information: (see notes below)			
	Legal Name (last name, first name, middle initial)			☐ Add coverage ☐ Cancel coverage
	Date of birth (yyyy/mm/dd)	Gender (☑) ☐ M ☐ F	Relationship to you? ☐ Spouse	☐ Dependent Child[1] ☐ Full-time Student[2] (19-24yrs) ☐ Disabled Dependent Child[3]
	Additional Information: (see notes below)			
	Legal Name (last name, first name, middle initial)			☐ Add coverage ☐ Cancel coverage
	Date of birth (yyyy/mm/dd)	Gender (☑) ☐ M ☐ F	Relationship to you? ☐ Spouse	☐ Dependent Child[1] ☐ Full-time Student[2] (19-24yrs) ☐ Disabled Dependant Child[3]
	Additional Information: (see notes below)			

[1] If adding an adopted child or ward, please provide the date you legally became the child's guardian and attach legal documents.
[2] If adding a full-time student aged 19 to 24yrs, please indicate the name of the school that the student is attending and the enrolment date.
[3] The Benefits Service Centre will contact you for further information if you are adding a disabled dependent child.

Section D

Benefit Plans

Plan	Election (☑)	Coverage Level (☑)
Medical Service Plan	☐ No Coverage[1] ☐ Elect Coverage [2, 3]	☐ Employee Only ☐ Employee & Spouse

List legal names of spouse/dependant(s) you wish to cover under this plan:

1. 4.
2. 5.
3. 6.

[1] All BC residents are required to enrol in MSP, so if you waive coverage here, you must be covered elsewhere.
[2] Initial Enrolment: You must also complete the *MSP Application for Group Enrolment Form.*
[3] Updating Coverage: You must also complete the *MSP Group Change Request Form.*

Extended Health Care	☐ No Coverage ☐ Coordination Option ☐ Comprehensive Option – Fully Funded ☐ Enhanced Option (2 year lock-in)	☐ Employee Only ☐ Employee plus 1 ☐ Employee plus 2(+)

List legal names of spouse/dependant(s) you wish to cover under this plan:

1. 4.
2. 5.
3. 6.

Dental Plan	☐ No Coverage ☐ Coordination Option ☐ Comprehensive Option – Fully Funded ☐ Enhanced Option (2 year lock-in)	☐ Employee Only ☐ Employee plus 1 ☐ Employee plus 2(+)

List legal names of spouse/dependant(s) you wish to cover under this plan:

1. 4.
2. 5.
3. 6.

Employee Basic Life Insurance [4, 5]	☐ Core $25,000 ☐ Comprehensive $80,000 – Fully Funded ☐ Enhanced (3 times annual salary)

[4] Evidence of insurability is not required during initial enrolment, but is required for any future increases.
[5] Please complete a *Group Life Beneficiary Designation* form and submit the original to the Benefit Service Centre.

Employee Optional Life Insurance [6, 7] ($1 million maximum)	In the last 12 months, have you smoked cigarettes? ☐ Yes ☐ No	☐ No Coverage ☐ Elect Coverage of units of $25,000

[6] You must Select Option 3 of Employee Basic Life Insurance to be eligible for coverage under this plan.
[7] Evidence of Insurability is required for coverage over $50,000 on your initial enrolment and for any future increases.

Spouse Optional Life Insurance [8, 9] ($500,000 maximum)	In the last 12 months, has your spouse smoked cigarettes? ☐ Yes ☐ No	☐ No Coverage ☐ Elect Coverage of units of $25,000 Name of Spouse:

[8] You must record the name of your spouse on this form if you elect this coverage.
[9] Evidence of Insurability is required for coverage over $50,000 on your initial enrolment and for any future increases.

Child/ren Optional Life Insurance ($20,000 maximum)	☐ No Coverage ☐ Elect Coverage of units of $5,000

List legal name(s) the dependant(s) you wish to cover under this plan:

1. 4.
2. 5.
3. 6.

Section D Benefit Plans	Plan	Election (☑)
	Employee Optional Accidental Death and Dismemberment Insurance ($500,000 maximum)	☐ No Coverage ☐ Elect Coverage of units of $25,000
	Spouse Optional Accidental Death and Dismemberment Insurance[1] ($500,000 maximum)	☐ No Coverage ☐ Elect Coverage of units of $25,000 Name of Spouse:
	[1]You must record the name of your spouse on this form if you elect this coverage.	
	Child(ren) Optional Accidental Death and Dismemberment Insurance ($250,000 maximum)	☐ No Coverage ☐ Elect Coverage of units of $10,000
	Please list the dependant(s) you wish to cover under this plan: 1. 4. 2. 5. 3. 6.	
	Optional Family Funeral Benefit[2]	☐ No Coverage ☐ Elect Coverage
	[2]Coverage of $10,000 for a spouse and $5,000 for each eligible dependent child.	
	Health Spending Account[3, 4]	☐ Waive ☐ Elect HSA. Total (Annual) Pledge is $
	[3]Allocations can only be made during initial enrolment or during Open Enrolment. You must confirm your allocation every year or your HSA will be waived. [4]If your first year in this program is a partial year, the annual election will be prorated over the number of months of coverage you have during that first year. Thereafter, your annual pledge will be divided over the full plan (calendar) year or 12 months.	

Section E Authorization		
	I certify that the information I have provided on this form is true and complete to the best of my knowledge. I understand that I may be required to provide proof or evidence of this information. I understand that premium rates for optional term life insurance are based on the individual's age, gender, and smoker/non-smoker status. If I have selected non-smoker rates, I understand that the insured individual must not have smoked cigarettes for at least the last 12 calendar months. I also authorize the employer to send necessary personal information to the benefit providers to initiate and maintain my coverage. By submitting my choices, I am authorizing the employer to take deductions, if applicable, from my paycheque to pay for my benefit costs.	
	Employee signature	Date signed (yyyy/mm/dd)

Freedom of Information and Protection of Privacy Act (FOIPPA) This information is collected by the British Columbia Public Service under s. 26(c) of FOIPPA. Any questions about the collection and the use of this information can be directed to an HR Service Representative at the BC Public Service Agency by submitting a request to AskMyHR, phoning: 1-877-277-0772 or writing to: Manager, Contact Centre Operations, BC Public Service Agency, 810 Blanshard Street, Victoria, BC V8W 2H2

For more information about your benefits, contact **MyHR** at: www.gov.bc.ca/myhr/contact.