Where ideas work

Bargaining Unit Benefits Program Enrolment/Change Form

Initial Enrolment:

1. Please review and complete all sections of the form and submit through AskMyHR using the category Myself (or) My Team/Organization > Benefits > Submit a Health Benefit Form/Application.
2. Applications must be received **no later than 31 days from the date of hire/eligibility**. You are eligible to select $50,000 of optional life insurance for yourself and your spouse evidence free within 31 days of being eligible for benefits. Any amount above $50,000 will require evidence of insurability and will not be effective until the application has been approved.
3. Applications received after the 31 days will not be effective until the first of the month following and you would have missed your opportunity to select any of the optional group life plans. You will be able to select optional group life plans if you experience an eligible life event, or once a year to be effective April 1st of the year.

Updating your Coverage:

1. You can update your extended health and dental plan at any time during the year. It will be effective the first of the month following receipt of your application.
2. You can update your optional group life plans due to an eligible life event. Applications must be received **no later than 60 days from the date of the eligible life event**. Complete only those sections where a change is required.
3. You can update your optional group life plans once a year to be effective April 1st of that year. Application must be received **by the last week in February.**
4. Submit forms for processing through AskMyHR using the category Myself (or) My Team/Organization > Benefits > Submit a Health Benefit Form/Application. Evidence of Insurability form for optional employee and spouse life insurance must be sent to the carrier and deductions will not be updated until coverage is approved by the carrier.

Section A: Employee Information (you must enrol under your legal name)

Legal Name (last name, first name, middle initial)		Gender ☐ Male ☐ Female
Home/Mailing address (Street, City Postal Code)		Email address
Ministry	Employee number	Date of birth (yyyy/mm/dd)
Employee class ☐ BCGEU ☐ PEA ☐ NURSES ☐ UNIFOR ☐ OTHER		

Section B: Purpose of Form

☐ Initial Enrolment	Have you returned to work after retiring? No ☐ Yes ☐	If yes, did you elect to maintain life insurance as a retiree? No ☐ Yes ☐
☐ Enrol/Update Extended Health or Dental Only		
☐ April 1st optional life insurance changes[1]		
☐ 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)		Gender M ☐ F ☐
Relationship to you?	☐ Spouse ☐ Dependent Child[2] ☐ Full-time Student[3] (19-24yrs) ☐ Disabled Dependent Child[4]	Date of birth (yyyy/mm/dd)
Additional Information:		☐ Add coverage ☐ Cancel coverage
Legal Name (last name, first name, middle initial)		Gender M ☐ F ☐
Relationship to you?	☐ Dependent Child[2] ☐ Full-time Student[3] (19-24yrs) ☐ Disabled Dependent Child[4]	Date of birth (yyyy/mm/dd)
Additional Information:		☐ Add coverage ☐ Cancel coverage
Legal Name (last name, first name, middle initial)		Gender M ☐ F ☐
Relationship to you?	☐ Dependent Child[2] ☐ Full-time Student[3] (19-24yrs) ☐ Disabled Dependent Child[4]	Date of birth (yyyy/mm/dd)
Additional Information:		☐ Add coverage ☐ Cancel coverage
Legal Name (last name, first name, middle initial)		Gender M ☐ F ☐
Relationship to you?	☐ Dependent Child[2] ☐ Full-time Student[3] (19-24yrs) ☐ Disabled Dependent Child[4]	Date of birth (yyyy/mm/dd)
Additional Information:		☐ Add coverage ☐ Cancel coverage

Section D: Benefit Plans (you must enrol your dependant(s) and spouse under their legal name(s))		
Plan / Coverage Level	**Election**	
Extended Health Care and Dental Plan ☐ Employee Only ☐ Employee plus 1 ☐ Employee plus 2(+)	☐ No Coverage ☐ Elect Coverage	List spouse/dependant(s) to cover under plan 1. 2. 3. 4. 5. 6.
Employee Basic Life Insurance	• Complete the Group Life Beneficiary Designation form	Original Group Life Beneficiary Designation form must be mailed to the address listed on top of the form
Employee Optional Life Insurance [5] (purchase in units of $25,000 to a maximum of $1 million coverage - please indicate the FULL AMOUNT of coverage that you are applying for whether it's greater or less than $50,000)	☐ No Coverage ☐ Elect Coverage of _____ units of $25,000 **Complete and submit** the Evidence of Insurability form if applying for coverage over $50,000 on initial enrolment, for coverage after initial enrolment in any amount or if applying for increased coverage	In the last 12 months, have you smoked cigarettes? [6] Yes ☐ No ☐
Spouse Optional Life Insurance [7] (purchase in units of $25,000 to a maximum of $500,000 coverage- please indicate the **FULL AMOUNT** of coverage that you are applying for whether it's greater or less than $50,000)	☐ No Coverage ☐ Elect Coverage of _____ units of $25,000 **Complete and submit** the Evidence of Insurability form if applying for coverage over $50,000 on initial enrolment, for coverage after initial enrolment in any amount or if applying for increased coverage	Name of Spouse: In the last 12 months, has your spouse smoked cigarettes? [6] Yes ☐ No ☐
Child/ren Optional Life Insurance (purchase in units of $5,000 to a maximum of $20,000 coverage)	☐ No Coverage ☐ Elect Coverage of _____ units of $5,000	List the dependant(s) to cover under this plan 1. 2. 3. 4. 5. 6.
Employee Optional Accidental Death and Dismemberment Insurance (purchase in units of$25,000 to a maximum of $500,000 coverage)	☐ No Coverage ☐ Elect Coverage of _____ units of $25,000	
Spouse Optional Accidental Death and Dismemberment Insurance [8] (purchase in units of $25,000 to a maximum of $500,000 coverage)	☐ No Coverage ☐ Elect Coverage of _____ units of $25,000	Name of Spouse:
Child/ren Optional Accidental Death and Dismemberment Insurance (purchase in units of $10,000 to a maximum of $250,000 coverage)	☐ No Coverage ☐ Elect Coverage of _____ units of $10,000	List the dependant(s) to cover under this plan 1. 2. 3. 4. 5. 6.
Optional Family Funeral Benefit [9]	☐ No Coverage ☐ Elect Coverage	

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)

Section F: Submitting

Submit Benefit forms for processing through:

- AskMyHR 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

Submit Evidence of Insurability form:

- Email: groupmed@canadalife.ca
- Mail: Canada Life Assurance Company
  Group Medical Underwriting
  PO Box 6000
  Winnipeg, MB R3C 3A5

Questions

Visit MyHR at: www.gov.bc.ca/myhr/

Notes

[1]Submit application by the end of the last week in February to be effective April 1st of each year if you would like to change your optional insurance plans. If you are increasing your life insurance for optional employee or spouse coverage you will be required to submit evidence of insurability to the insurance carrier. The new insurance amount will not be in effect until your application has been approved by the insurance carrier.

[2]If adding an adopted child or ward, provide the date you legally became the child's guardian and attach legal documents.

[3]If adding a full-time student aged 19 to 24 years, indicate the name of the school that the student is attending and the enrolment date.

[4]The Benefits Service Centre will contact you for further information if you are adding a disabled dependent child.

[5]Evidence of insurability is required for coverage over $50,000 on your initial enrolment, for coverage after initial enrolment in any amount or for any future increases.

[6]Smoking status is based on whether the applicant has smoked or used cigarettes, e-cigarettes, cigarillos, pipe, cigars, nicotine patch and/or gum, chewing tobacco, hookah, or tobacco or nicotine products in any other form.

[7]You must record the name of your spouse on this form if you elect this coverage. Evidence of insurability is required for coverage over $50,000 on your initial enrolment, for coverage after initial enrolment in any amount or for any future increases.

[8]You must record the name of your spouse on this form if you elect this coverage.

[9]Coverage of $10,000 for a spouse and $5,000 for each eligible dependent child. You are the beneficiary.

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 for the purpose of administering this program. Any questions about the collection and the use of this information can be directed in writing to the Manager, Benefit Design and Programs, 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.