Flexible Benefits Program Enrolment/Change Form

Initial Enrolment:

1. Please review and complete all sections of the form and submit to MyHR.
2. Forms must be received **no later than 31 days from your date of hire/eligibility** or you will receive the default benefits package. You are eligible to select $50,000 of optional life insurance for yourself or 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. Left-over flex credits will be paid out monthly as taxable income.

Updating your Coverage:

1. 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.
2. 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).
3. Submit forms for processing through an AskMyHR Online Service Request by selecting "Myself (or) "My Team/Organization" then "Benefits" and then "Submit a Health Benefit Form/Application" or submit by fax or mail.

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

Legal Name (last name, first name, middle initial)		Gender M ☐ F ☐
Home/Mailing address (Street, City Postal Code)		Email address
Ministry	Employee number	Date of birth (yyyy/mm/dd)

Section B: Purpose of Form

☐ Initial Enrolment		
☐ Open Enrolment[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]	☐ Add coverage ☐ Cancel coverage
Additional Information: (see notes below)		Date of birth (yyyy/mm/dd)
Legal Name (last name, first name, middle initial)		Gender M ☐ F ☐
Relationship to you?	☐ Dependent Child[2] ☐ Disabled Dependent Child[4] ☐ Full-time Student[3] (19-24yrs)	☐ Add coverage ☐ Cancel coverage
Additional Information: (see notes below)		Date of birth (yyyy/mm/dd)
Legal Name (last name, first name, middle initial)		Gender M ☐ F ☐
Relationship to you?	☐ Dependent Child[2] ☐ Disabled Dependent Child[4] ☐ Full-time Student[3] (19-24yrs)	☐ Add coverage ☐ Cancel coverage
Additional Information: (see note below)		Date of birth (yyyy/mm/dd)
Legal Name (last name, first name, middle initial)		Gender M ☐ F ☐
Relationship to you?	☐ Dependent Child[2] ☐ Disabled Dependent Child[4] ☐ Full-time Student[3] (19-24yrs)	☐ Add coverage ☐ Cancel coverage
Additional Information: (see notes below)		Date of birth (yyyy/mm/dd)

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Section D: Benefit Plans (you must enrol your dependant(s) and spouse under their legal name(s))

Plan / Coverage Level	Election	
Medical Service Plan ☐ Employee Only ☐ Employee & Spouse	☐ No Coverage[5] ☐ Elect Coverage[6,7] • Complete the MSP application for group enrolment or the MSP group change request	List legal names of spouse/dependant(s) to cover under plan 1. 2. 3. 4. 5. 6.
Extended Health Care ☐ Employee Only ☐ Employee plus 1 ☐ Employee plus 2(+)	☐ No Coverage ☐ Coordination Option ☐ Comprehensive Option – Fully Funded ☐ Enhanced Option (2 year lock-in)	List legal names of spouse/dependant(s) to cover under plan 1. 2. 3. 4. 5. 6.
Dental Plan ☐ Employee Only ☐ Employee plus 1 ☐ Employee plus 2(+)	☐ No Coverage ☐ Coordination Option ☐ Comprehensive Option – Fully Funded ☐ Enhanced Option (2 year lock-in)	List legal names of spouse/dependant(s) to cover under plan 1. 2. 3. 4. 5. 6.
Employee Basic Life Insurance [8, 9]	☐ Core $25,000 ☐ Comprehensive $80,000 – Fully Funded ☐ Enhanced (3 times annual salary)	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 [10,11] ($1 million maximum)	☐ No Coverage ☐ Elect Coverage of _____ units of $25,000 • Complete the Evidence of Insurability form	In the last 12 months, have you smoked cigarettes? [12] Yes ☐ No ☐
Spouse Optional Life Insurance[11,13] ($500,000 maximum)	☐ No Coverage ☐ Elect Coverage of _____ units of $25,000 • Complete the Evidence of Insurability form	Name of Spouse: In the last 12 months, has your spouse smoked cigarettes? [12] Yes ☐ No ☐
Child/ren Optional Life Insurance ($20,000 maximum)	☐ 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 ($500,000 maximum)	☐ No Coverage ☐ Elect Coverage of _____ units of $25,000	
Spouse Optional Accidental Death and Dismemberment Insurance[13] ($500,000 maximum)	☐ No Coverage ☐ Elect Coverage of _____ units of $25,000	Name of Spouse:
Child(ren) Optional Accidental Death and Dismemberment Insurance ($250,000 maximum)	☐ 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[14]	☐ No Coverage ☐ Elect Coverage	
Health Spending Account[15, 16]	☐ Waive ☐ Elect HSA. Total (Annual) Pledge is $	

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@gwl.ca**
- Mail: The Great-West Life Insurance 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 Open Enrolment deadline each fall for coverage to be effective January 1st. If you are increasing your life insurance for optional employee or spouse coverage you will be required to submit evidence of insurability. 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, please provide the date you legally became the child's guardian and attach legal documents.
[3]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.
[4]The Benefits Service Centre will contact you for further information if you are adding a disabled dependent child.
[5]All BC residents are required to enrol in MSP, so if you waive coverage here, you must be covered elsewhere.
[6]Initial Enrolment: You must also complete the *MSP Application for Group Enrolment Form*.
[7]Updating Coverage: You must also complete the *MSP Group Change Request Form.*
[8]Evidence of Insurability is not required during initial enrolment, but is required for any future increases.
[9]Please complete a *Group Life Beneficiary Designation* form and submit the original to the Benefits Service Centre.
[10]You must select Option 3 (Enhanced) of Employee Basic Life Insurance to be eligible for coverage under this plan.
[11]Evidence of Insurability is required for coverage over $50,000 on your initial enrolment and for any future increases.
[12]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.
[13]You must record the name of your spouse on this form if you elect this coverage.
[14]Coverage of $10,000 for a spouse and $5,000 for each eligible dependent child.
[15]Allocation can only be made during initial enrolment of during Open Enrolment. You must confirm your allocation every year or your HSA will be waived.
[16]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 of 12 months.

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**.