BCCA Employee Benefit Trust Group Enrolment Form

Please send completed form to:
BCCA Employee Benefit Trust
120-4401 Still Creek Drive Burnaby BC V5C 6G9
hr@bccabenefits.ca
604-683-7353 1-800-665-1077 fax: 1-604-299-2982

ID Number: (EBT Use)

☐ **New Employee**
☐ **Rehired Employee**

Name of Employer_____

Policy No._____ **Group Code** (EBT use) _____

Employee Information — Please Print Clearly

First Name	**Last Name**	**Middle**	**SIN:** (Optional)
Mailing Address	**City**	**Prov.**	**Postal Code**

Sex	**Birth Date**			**Email** (Optional)**:**	**Telephone** (Optional)**:**
	Month	**Day**	**Year**		
☐ **Male** ☐ **Female**				**Marital Status:** ☐ Single ☐ Married ☐ Common Law* ☐ Widowed ☐ Divorced/Separated	*Date of Cohabitation_____ (*Date of Cohabitation is mandatory for Common Law status).

List Dependent(s) – Spouse and children (if you require more room please attach another enrolment form)		**Sex**	**Birth Date**			**Relationship to You**	If a child is over 19, please provide the name of the full time school OR attach a copy of the CRA approved application for Disability Tax Credit decision.
First Name	**Last Name** (if different from your own)	**M/F**	**Month**	**Day**	**Year**		

Coordination of Extended Health and Dental Coverage

Do you and/or your dependents have extended health or dental coverage under another plan? If yes you MUST provide the other insurance carriers details below.

Name of Insurance Company	**Policy No.**	**ID. No.**	☐ **Single Coverage** ☐ **Family Coverage**

As you have comparable coverage you have the option to waive health and/or dental benefits below. To coordinate between both plans please leave the below section blank.

By checking the boxes below, **I am choosing to decline the benefit for myself and my dependents** ☐ Extended Health Care ☐ Dental Care

OR

By checking the boxes below, **I am choosing to decline the benefit for my dependents only** ☐ Extended Health Care ☐ Dental Care

Life Insurance Beneficiary Designation

_____ Full Legal Name _____ Relationship to you _____% Share of Proceed

_____ Full Legal Name _____ Relationship to you _____% Share of Proceed

*If you would like to add more beneficiaries than the space above allows, please add another enrolment form

_____
Full Legal Name of Trustee (required for beneficiaries under the age of majority, 19 in B.C. If no Trustee is listed the PGT of BC will be assigned)

Where Quebec laws apply, a spouse beneficiary is irrevocable unless you check this box designating it revocable.

☐ Revocable

An irrevocable beneficiary designation cannot be changed without the written consent of the irrevocable beneficiary.

OR, To assign your estate as your beneficiary, indicate "Estate". If no beneficiary is assigned, your estate will automatically be assigned.

I consent to the collection, use and exchange of my personal information by my plan sponsor, the administration of my group benefits program, the agents retained by my plan sponsor of the administrator, the insurance company providing benefits, and/or other person who requires information for the purpose of group benefits plan administration. I authorize these parties to obtain, and exchange between them, any information about me, my spouse, or my dependent children that they require for the purposes of determining my benefit entitlements, and for record-keeping, file identification, reporting, underwriting, procurement of health information, claims adjudication and resolution, program management, and other services provided to me and my plan sponsor from time to time. I confirm that I have obtained the consent required of my spouse and any dependent children over the age of majority to permit me to give the above consent as it relates to their personal information. I hereby confirm the above beneficiary designation, which replaces any previous revocable beneficiary. I reserve the right to change my revocable beneficiary designation at any time. I hereby apply for group insurance benefits under my plan sponsor's plan and authorize any required deductions. If I should receive a settlement from, or a judgement against, a liable third party for wage loss, extended health, or other benefits covered under my group plan, I agree and authorize the third party to reimburse the insurance company providing benefits up to the amount of benefits advanced to me pending such settlement or judgement. I consent to the use of my social insurance number for tax reporting purposes and as an identification number where it is required in the administration of the plan. By including my email above I consent to receiving updates, resource and correspondence emails regarding my benefit plan. I understand that on the date my insurance becomes effective I must be actively at work and on the date the insurance of my dependent(s) becomes effective they cannot be confined to hospital. I certify that the information given above is true and complete.

Employee Signature X_____ Date _____

Employment Information: For a Plan Administrator / Employer to complete

Is the employee in Canada on a Work Visa/Permit? ☐ Yes (please provide a copy) ☐ No

Is the employee covered by a Provincial Health Plan? Examples: BC Care Card, AHCIP in Alberta or OHIP in Ontario ☐ Yes Prov.:_____ ☐ No

$_____ Employee Earnings	☐ Monthly ☐ Annually ☐ Bi-weekly ☐ Weekly ☐ Hourly	Enrolled via EAS ☐	H.S.A Allocation (if applicable)	Hours Worked/Week	Employee Occupation:

Date of Hire* (New Employee)			**Date of Re-hire** (Re-hired Employee)			Division	Class
MM	DD	YY	MM	DD	YY		

I confirm that this individual is an active permanent employee and the information I have provided is complete and true.

Waive waiting period?* ☐ Yes

X _____
Authorized Signature of Employer **Date**

***Unless otherwise advised, the effective date will be determined by the date of hire and the waiting period as defined by your master application.**
A copy or original of this form should be kept in the employee's file for your records