Catholic Independent Schools of Vancouver Archdiocese in Association with Canada Life Assurance Company
Policy No. 's. 335645, 335646 & 56565 / Division 10

APPLICATION FOR GROUP BENEFIT COVERAGE

MANDATORY PARTICIPATION REQUIRED FOR ALL ELIGIBLE EMPLOYEES

Instructions: 1) Complete the form electronically. A handwritten form will not be accepted.
2) The employer must email a scanned copy to the Benefits Administration Office.

This section is for Benefits Administration Office's use only.	
A. Employee ID number:	
B. Group Critical Illness Applies to all employees under the age of 69 and covered under Class 1, 2, & 4.	
Critical Illness policy 100005769 is in-force effective (MMM-DD-YYYY):	

1. Policyholder Section – to be completed by **Employer** (Benefit Representative).

Employer Name:							
Employer No.:		Benefit Class:					
Original Hire Date: (**must be provided**)		Month:		Day:		Year:	
Effective Date of Coverage:		Month:		Day:		Year:	
Late Applicant?	☐ Yes ☐ No	Identified as:	☐ Catholic or ☐ Non-Catholic	Please specify:			
Occupation:		Gross Annual Earnings:					
Income earned/paid within the MONTH of the effective date of coverage:		$					
No. of hours worked per week:		No. of Days worked per week:		No. of Weeks PAID per year:			

(minimum 20 hours per week requirement for coverage) (For STD purposes, minimum weeks per year is 43)

2. Employee Information – to be completed by the **Employee**.

Legal Name:	First Name	Middle Name	Last Name
Gender:	Date Of Birth: (MMM-DD-YYYY)	SIN:	
Mailing Address:	Apt./Unit#, Street number, Street Name, City, Province, Postal Code		
Home Phone:		Mobile Phone:	
Personal Email:		Work Email:	
Do you have a spouse (legally married)?	☐ Yes ☐ No Other:		
Do you have a dependent child (incl: full-time post-secondary student or disabled dependent)?	☐ Yes ☐ No		

3. Registered Pension Plan (RPP) – To be completed by eligible Benefit Class 1, 2, and 100 Employee and Class 4 from PG Diocese. NOTE: It is not mandatory to enroll in the Registered Pension Plan; however, you CANNOT opt-out once you have registered.

☐ No, at this time, I choose to opt-out of the RPP program; or

☐ Yes, I would like to enroll in the RPP program. I understand that while employed, I cannot withdraw from or terminate my RPP contributions. (**Application for membership in an RPP MUST be completed).** My employer-matched contribution level will be (**choose one**): ☐ 3% OR ☐ 7%

☐ My Voluntary Pension contribution will be $_____ per month. (The ER does NOT match voluntary pension contributions)

4. Refusal of Benefits – To be completed by Employee. Important: Extended Health and Dental benefits are the only benefits that can be refused if you and your dependents have duplicate group benefits covered through your spouse's employer. **The Employee MUST complete this section to waive the extended health or dental benefits. If the information is NOT provided, extended health or dental coverage will NOT be waived.** I understand the plan of group benefits offered to me, but **decline** to participate in:

Waive Extended Health Benefits for:	☐	Myself and my dependents	☐	My dependents only (Single coverage for myself)
Waive Dental Benefits for:	☐	Myself and my dependents	☐	My dependents only (Single coverage for myself)

Other insurance information: Policy No.:

BC Fair PharmaCare Registration: To be completed by the Employee. *Applies to ALL employees who have Group Extended Health Coverage (335645)*

☐ I am registered under the BC Fair PharmaCare. My registration number is:

☐ I am NOT registered under the BC Fair PharmaCare but will submit my registration number after registering to BC Fair PharmaCare. **EE's Initial:**

7. Authorizations and Declarations – I hereby apply for coverage under the group benefits plan issued by Canada Life.

I authorize:

- My employer to deduct form my pay and remit to Canada Life the plan member contributions required under the plan, if applicable;
- Canada Life to use my social insurance number for tax reporting purposes where it is required in the administration of the plan;
- Canada Life, any healthcare provider, my Benefit Representative at the local level, the Benefit Administration office, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Canada Life to exchange personal information, when necessary to determine my eligibility for coverage and to administer the plan.

If applying for coverage for my spouse and/or dependents, I confirm that I am authorized to act on their behalf. I agree that a photocopy or electronic copy of this Authorizations and Declarations section is as valid as the original. I certify that the information given is true, correct and complete to the best of my knowledge.

EmployEE signature: **Date:**

EmployER signature: **Date:**

Received by CISVA – Benefit Administration Office: