



APPLICATION FOR GROUP BENEFIT COVERAGE

MANDATORY PARTICIPATION TO GROUP BENEFITS 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.

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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).												
School/Parish Name:												
School/Parish ER#:			Benefit Class:									
Original Hire Date: (must be provided)			Month:		Day:		Year:					
Effective Date of Coverage:			Month:		Day:		Year:					
Contract End Date (if not a continuing contract):			Month:		Day:		Year:					
Is there an intention to rehire?:		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Late Applicant?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Identified as:		<input type="checkbox"/> Catholic	<input type="checkbox"/> Non-Catholic	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:						
<small>(minimum 20 hours per week requirement for coverage)</small>						<small>(For STD purposes, minimum weeks per year is 43)</small>						

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)? <input type="checkbox"/> Yes <input type="checkbox"/> No Other:									
Do you have a dependent child (incl: full-time post-secondary student or disabled dependent)? <input type="checkbox"/> Yes <input type="checkbox"/> 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.									
<input type="checkbox"/> No, at this time, I choose to <u>opt-out</u> of the RPP program; or									
<input type="checkbox"/> 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 _____% <small>[1-9% for CISVA 3% or 7% for other employers]</small>									
<input type="checkbox"/> My Voluntary Pension contribution will be \$_____ per month. (The ER does NOT match voluntary pension contributions)									
4.a. Group Health and Dental Benefits – to be completed by the 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:					Waive Dental Benefits for:				
<input type="checkbox"/> Myself and my dependents					<input type="checkbox"/> My dependents only (Single coverage for myself)				
<input type="checkbox"/> Myself and my dependents					<input type="checkbox"/> My dependents only (Single coverage for myself)				
Other insurance information:						Policy No.:			

4.b. BC Fair PharmaCare Registration: To be completed by the Employee. Applies to ALL employees who have Group Extended Health Coverage (335645)									
<input type="checkbox"/> I am registered under the BC Fair PharmaCare. My registration number is:									
<input type="checkbox"/> I am NOT registered under the BC Fair PharmaCare but will submit my registration number after registering to BC Fair PharmaCare.								EE's Initial:	

5. Authorizations and Declarations – I hereby apply for coverage under the group benefits plan issued by Canada Life.									
I authorize: <ul style="list-style-type: none"> • My employer to deduct from 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:				

