



Retiree Benefit Plan Programme

RETIREE ENROLLMENT FORM for 2025-2026

Please select ():

New Applicant

Cancel Coverage

Effective Date: _____

What you need to do:

Know:

- that available retiree benefits are for Extended Health and Dental benefits only.
- that coverage may be for a variation of single, couple or family coverage for Extended health and Dental benefits.
- that the retiree benefits coverage booklet (Benefit Class 5) can be found online at www.rcavgroupplan.org/group-benefits
- that inquiries regarding benefit eligibility should be directed to Canada Life at 1-800-957-9777
- that there is an administration fee of \$3.00 per month (\$30.00/year) to participate in the retiree program
- *every insufficient fund (NSF) will incur a \$30.00 fee.*

Report:

- any changes to your status, etc., that may have a direct impact on your premiums (ie: an increase or decrease to your number of dependents)
- any new/changed/alternative contact information. Example: you may live out-of-province/country for part of the year. If so, please report your alternate contact information on the back of this form.

Submit:

- premiums by the appointed deadline. As with all insurance policies, arrears of premium contributions may lead to the termination of your policy. It is your responsibility to ensure that your account is always paid up to date.

Rates for the 2025-2026 policy year (10 month premiums/ 12 months coverage):

Dental:	Single: \$ 103.64 x 10	Couple: \$ 207.30 x 10	Family: \$ 255.36 x 10
Extended Health:	Single: \$ 119.53 x 10	Couple: \$ 238.09 x 10	Family: \$ 352.42 x 10
Administration Fee:	+\$ 3.00 x 10	+\$ 3.00 x 10	+\$ 3.00 x 10

Please select () coverage:

- Dental:** Single Dental Couple Dental Family Dental Cancel Dental
- Ext. Health:** Single Ext. Health Couple Ext. Health Family Ext. Health Cancel Ext. Health

Send your Pre-authorized Debit Form to our office. **Premiums will be deducted from your account on the 1st day of the month.** Please sign below and return it to the Benefits Administration Office.

(Please print clearly)

Member Identification Number:

NAME: _____

PHONE: _____

ADDRESS:

CITY: _____

POSTAL CODE: _____

EMAIL ADDRESS: _____

SIGNATURE: _____

DATE: _____