PUBLIC EDUCATION BENEFITS TRUST

Enrolment Form

COMPLETE THIS FORM FOR THE ADDITION OF A NEW PLAN MEMBER

This form is to be completed on the date of hire for new employees. Keep the original on file, as it will be required by the insurer if there is a future death or disability claim.

- Section 1 to be fully completed by Plan Sponsor/Employer
- Sections 2 - 6 to be fully completed by Plan Member/Employee
- Return ORIGINAL to your School Disrict Benefits Administrator

This Enrolment Form complies with the requirements of the Insurers for the PEBT Benefits Program and the information they require to underwrite and administer the benefits plans that are made available

○ New Applicant ○ Reinstatement

1 Plan Sponsor/Employer Information

District	District ID Number	Class	Division
Cost Centre (If applicable) / Employee Hire/Rehire Date: YYYY / MM / DD	Employee Effective Date: YYYY / MM / DD	ID Number	
Occupation/Position / Earnings Per ___ $	Policy/Group Contract Numbers	Hours Worked/Week	
Employment Type: ○ Full-Time ○ Part-Time ○ Seasonal/Contract ○ Other:	Employment Status: ○ Regular ○ Temporary	Waiting Period (If applicable)	

2 Plan Member/Employee Information

Last Name	First Name	Middle Initial
Marital Status: ○ Single ○ Married ○ Seperated ○ Widowed ○ Divorced ○ Civil Union ○ Common-Law*	* Date Of Cohabitation For Common-Law: YYYY / MM / DD	
Mailing Address	E-mail Address	Sex: ○ M ○ F
City / Province / Postal Code	Provincial Health Plan Number (Care Card)	Date of Birth: YYYY / MM / DD

3 Plan Member/Employee Coverage and Family Information

Please list all of your eligible dependents, even if you select single coverage

Do you have a spouse and/or dependent(s)? ○ Yes ○ No	Required Health Coverage: ○ Single ○ Couple ○ Family	Health Effective Date
Do you have a spouse and/or dependent(s)? ○ Yes ○ No	Required Dental Coverage: ○ Single ○ Couple ○ Family	Dental Effective Date
Spouse's Surname	Spouse's First Name	Spouse's Date of Birth: YYYY / MM / DD — Sex: ○ M ○ F
Does your spouse have benefits through an employer plan? ○ Yes ○ No	Employment Type: ○ Full-Time ○ Part-Time ○ Retiree	If yes, please provide policy #, effective date and ID:

Please indicate your spouse's coverage:

Health: ○ Single ○ Couple ○ Family

Dental: ○ Single ○ Couple ○ Family

Child's full name (last, first)	Date of Birth	Sex	Student **	Disabled ***
	YYYY / MM / DD	○ M ○ F	○ Yes ○ No	○ Yes ○ No

** Provide name of school and student number of child if over 21 and studying full time

*** If child is a person with a disability, state nature of disability and attach a completed PBC Disabled Dependent Application Form

Child's full name (last, first)	Date of Birth	Sex	Student **	Disabled ***
	YYYY / MM / DD	○ M ○ F	○ Yes ○ No	○ Yes ○ No

** Provide name of school and student number of child if over 21 and studying full time

*** If child is a person with a disability, state nature of disability and attach a completed PBC Disabled Dependent Application Form

Child's full name (last, first)	Date of Birth	Sex	Student **	Disabled ***
	YYYY / MM / DD	○ M ○ F	○ Yes ○ No	○ Yes ○ No

** Provide name of school and student number of child if over 21 and studying full time

*** If child is a person with a disability, state nature of disability and attach a completed PBC Disabled Dependent Application Form

To be eligible for benefits coverage, your dependent children must meet the dependent child definition outlined on the PEBT website. Disabled dependents may be eligible for benefits coverage if they became disabled before the limiting age outlined on the PEBT website and are completely dependent on you for financial support. Eligible dependents may vary depending on the benefit plan. Check with your School District Benefits Administrator for further information.

4 Waiver of Benefits

If you waive health and/or dental coverage and later lose coverage through another plan, you may apply for benefits under this plan within 4 months. Otherwise you and/or your dependents may be required to provide proof of insurability, and your benefits may be limited or denied under this plan.

If you or your dependents are presently covered for health and/or dental benefits under another benefits plan you may be able to waive coverage for such benefit(s) under this plan.

I waive coverage for myself and my dependents under :

○ Health ○ Dental

I waive coverage for my dependents under:

○ Health ○ Dental

5 Plan Member/Employee Beneficiary Information

If you designate a beneficiary who is:

(a) under 18 years of age, or
(b) mentally incapacitated

you should also designate a Trustee for that beneficiary. If this situation applies to you or you have concerns about your named beneficiary's legal status, please consult a legal advisor for further details.

Original beneficiary information will be kept by your Plan Sponsor/Employer.

Name your beneficiary(ies)

Beneficiary's Last Name		Beneficiary's First Name
Relationship to Plan Member	Percent allocated Basic/Optional Life %	Percent allocated Basic AD&D %
Beneficiary's Last Name		Beneficiary's First Name
Relationship to Plan Member	Percent allocated Basic/Optional Life %	Percent allocated Basic AD&D %
Beneficiary's Last Name		Beneficiary's First Name
Relationship to Plan Member	Percent allocated Basic/Optional Life %	Percent allocated Basic AD&D %

I appoint _____ as Trustee to receive any amount designated to a beneficiary who is under the age of 18 or mentally incapacitated.

6 Plan Member/Employee Declaration

I consent to the collection, use, and disclosure of my personal information by my Plan Sponsor/Employer or the administrator, an insurance company, or any other person or organization having any relevant information about me (collectively “the Parties”) who require this information for the purpose of administering my group benefits under the plan.

I authorize the Parties to obtain and exchange between them, any personal information about me, my spouse, and my dependent children for the purpose of determining benefit entitlements, and for record keeping, file identification, reporting, underwriting, procurement of health information, claims adjudication and resolution, program management, administration of the plan and other benefits administration services provided from time to time.

Plan Member/Employee Signature

Date Signed