

CONFIRMATION OF ELIGIBILITY – TEACHER TEACHING ON CALL

Part I: To be completed by Administrator:

EMPLOYER'S NAME (SCHOOL DISTRICT)	DIVISION	EMPLOYEE I.D. NUMBER
EMPLOYEE'S FAMILY NAME	GIVEN NAME(S)	DATE OF HIRE
ELIGIBILITY REQUIREMENTS (e.g. Waiting period, Minimum # of hours or percentage of FTE an employee must work to be deemed eligible)		BENEFITS ELIGIBLE FOR: <input type="checkbox"/> Extended Health Care <input type="checkbox"/> Dental Care

Part II: To be completed by Employee if coverage is requested, confirmed by Administrator (Initials)
To apply for benefits, attach this completed form to a Group Insurance Application and return to Administrator.

FIRST DAY WORKED _____ Administrator	DETAILS OF TIME WORKED TO SATISFY ELIGIBILITY (Dates, # of days if necessary) _____ Administrator	ELIGIBILITY DATE (The date when your insurance becomes effective) _____ Administrator
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Guidelines:

1. If you elect coverage, you will be responsible for 100% of the cost of monthly premiums, payable in advance.
2. Time worked cannot be accumulated in more than one district. Additionally, the minimum work week can be based on an average amount of time worked per week over the last school year.
3. If you are employed by more than one district, you may choose to join ONE of those districts' plans, provided the necessary requirements are met. Once enrolled, you may not join another district's plan until employment, within the district in whose plan you are participating in, ends.
4. If you elect coverage after four (4) months have passed since your date of eligibility, satisfactory medical evidence must be supplied. For Extended Health Care benefits, late applicants must submit a completed Statement of Health (in some instances, PBC will need additional information from a medical practitioner in order to assess your health and the costs for this additional information would be your responsibility). For Dental Care benefits, late applicants must submit a completed Dental Examiner's Report.
5. If the amount of time worked falls below the minimum after joining a benefits plan, coverage will continue until the beginning of the next school year. If you do not meet the eligibility requirements at the beginning of the next school year, coverage will be terminated September 30.
6. Coverage ends when you are no longer a TTOC with the district.
7. If you elect to cancel your coverage (for reasons other than you become eligible under a spouse's plan), you will not have the option of joining the plan at a future date. You will need to submit a completed Refusal of Coverage form (Covered Employee section).
8. If you elect to cancel your coverage due to becoming eligible under a spouse's plan, you will need to submit a completed Refusal of Coverage form (Covered Employee section). If you wish to rejoin the plan due to loss of coverage under a spouse's plan, you may submit a Group Insurance Application within 31 days of termination of the spousal coverage. If received within this timeframe Late Application Rules (see #4) will not apply.

Upon approval of coverage, you can visit www.bcpseabenefits.ca select your district and employee groups from the drop down menus to view the provisions of the applicable Group Insurance Policy.

PBC reserves the right to final approval of all Applications for Benefits. Coverage will be subject to plan limitations.

CERTIFICATION

I hereby certify that I understand all guidelines and requirements for eligibility, as stated above. I realize that it is my responsibility to apply for benefits when I become eligible. If I do not apply when I become eligible, I realize that if I apply for benefit coverage at a later date, my application will be subject to medical evidence.

Date _____

Employee _____

ACCEPTANCE

I hereby certify that the above-named Employee has met all eligibility requirements for participation in the benefit plans for which he/she is eligible, as stated above.

Date _____

Administrator _____