



BENEFIT PLAN ENROLMENT FORM

- INITIAL ENROLMENT
 DATA CHANGE

Last Name	First	Middle	Gender	Employee Number								
			<input type="checkbox"/> MALE									
			<input type="checkbox"/> FEMALE									
Address	Street	City	Province	Postal Code								
PART I EMPLOYEE INFORMATION (see information on reverse)												
I	Employee Type	<input type="checkbox"/> Permanent Full-Time <input type="checkbox"/> Labour Service <input type="checkbox"/> Permanent Part-Time <input type="checkbox"/> Term										
II	Employee Birth Date	<table style="width:100%; border:none;"> <tr> <td style="border-bottom: 1px solid black; width: 30%;"></td> <td style="border-bottom: 1px solid black; width: 10%;"></td> <td style="border-bottom: 1px solid black; width: 10%;"></td> <td style="border-bottom: 1px solid black; width: 49%;"></td> </tr> <tr> <td style="text-align:center;">Month</td> <td style="text-align:center;">Date</td> <td style="text-align:center;">Year</td> <td></td> </tr> </table>							Month	Date	Year	
Month	Date	Year										
PART II DEPENDENT INFORMATION (see information on reverse/attach another form if necessary).												
		Gender	Student	Disabled								
		M F										
		<input type="checkbox"/>	<input type="checkbox"/>									
Spouse (Surname, First Name, Initial)				Date of Birth (D/M/Y)								
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
Dependent (Surname, First Name, Initial)				Date of Birth (D/M/Y)								
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
Dependent (Surname, First Name, Initial)				Date of Birth (D/M/Y)								
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
Dependent (Surname, First Name, Initial)				Date of Birth (D/M/Y)								
PART III DEPENDENT INFORMATION REGARDING EMPLOYMENT WITH EXECUTIVE GOVERNMENT												
If your spouse is currently an employee of Executive Government, please complete this section.												
		Employee Number	Social Insurance Number	SGEU	CUPE	Out-of- Scope	Department					
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Spouse (Surname, First Name, Initial)												
PART IV EMPLOYEE CERTIFICATION AND SIGNATURE												
I certify that the information given is true, correct and complete to the best of my knowledge and promise to immediately notify my Human Resources Branch in writing of any change to the employee and/or dependent information indicated above.												
By failing to do so, I waive all right to make a claim for expenses incurred during that period of time my employee and/or dependent information was incorrect.												
I authorize the use of my Social Insurance Number by the Public Employees Benefits Agency or its agents as my personal identification number.												
_____ Employee Signature				_____ Date								

PART V EMPLOYER USE ONLY

Extended Health Care Plan

- Single - employee with no eligible dependents.
- Couple - employee with one eligible dependent: (1 spouse or 1 dependent child).
- Family - employee with two or more eligible dependents: (1 spouse and 1 or more dependent children, or no spouse and 2 or more dependent children).
- Insured under spouse plan – not set up as insured employee.

Public Employees Dental Plan

- Single - employee with no eligible dependents.
- Couple - employee with one eligible dependent: (1 spouse or 1 dependent child).
- Family - employee with two or more eligible dependents: (1 spouse and 1 or more dependent children, or no spouse and 2 or more dependent children).

Authorized Signature

Date

Employee Enrolment Information

This form must be returned to your Human Resources Branch for authorization prior to you becoming eligible for coverage.

A copy will be returned to you once authorized by your Human Resources Branch.

If you do not receive your authorized copy within 31 days, contact your Human Resources Branch to confirm that your enrolment has been made.

Employee Eligibility

You are eligible for coverage if you are:

- a) a permanent full-time employee with at least six months continuous service;
- b) a non-permanent part-time or term employee with at least six months service who has met the minimum 37.5% hours of work requirement; or
- c) a labour service employee with at least six months service.

Dependent Eligibility

A spouse is:

- a) a legally married spouse or,
- b) a common-law spouse with whom the employee has cohabited for at least 12 consecutive months, such that spouses need not be persons of the opposite sex.

Your dependent children include:

- a) a child or step-child under 21 years of age for whom you are legally and financially responsible;
- b) a child or step-child between the ages of 21 and 25 inclusive, whom you support and who is attending a educational institution on a full-time basis; or
- c) a child or step-child 21 years of age and over who is solely dependent upon you due to a mental or physical disability.

Children for whom you have been granted custody pursuant to an Order of a Court are also eligible for coverage.