Comox Valley Schools
A Community of Learners
INNOVATIVE • INQUISITIVE • INCLUSIVE

BRITISH COLUMBIA PUBLIC SCHOOL EMPLOYERS' ASSOCIATION
SOLUTIONS AT WORK

Group Enrolment Form

O New applicant O Reinstatement

Part 1: Employee and Basic Insurance Information

Employee's Last Name	First Name	Initial	ID Number		Provincial Health Plan Number (Care Card)
Street Address	E-mail Address		Birthdate (MM/DD/YY)	Gender O M O F	Family Status O Single O Couple O Family
City	Province	Postal Code			

Dependents

First Name	Initial	Last Name (if different from Employee)	Birthdate (MM/DD/YY)	Relationship	Gender (M/F)	Required coverage	Provide name of school **and student number** below if child is over 21 and studying full time. If child is disabled, state nature of disability and attach full details. If adding an adopted child, provide date of adoption. If adding a legal ward, provide court document.
						O Health O Dental	
						O Health O Dental	
						O Health O Dental	
						O Health O Dental	

Part 2: Spousal or Other Coverage

Are you or your dependents covered for extended health and/or dental benefits by another	Benefit	Name of Carrier/Policy #	Effective Date	ID Number	Coverage
O No O Yes (specify)	Dental				O Single O Couple O Family
	Health				O Single O Couple O Family

Part 3: Beneficiary Designation

Complete the following section to appoint a beneficiary for any benefits payable on your death.

Beneficiary for Basic Life Last Name	First Name	Initial	Date of Birth (MM/DD/YY)	Share of Proceeds %	Relationship	Name of Trustee for Beneficiaries Under 18
				%		
				%		
				%		

Part 4: Personal Data Consent

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 services provided from time to time.

I confirm that I have obtained consent from my spouse and any dependent children over the age of majority, to disclose their personal information to the Parties as required for the administration of the plan.

In the case of death, I expressly authorize my employer, the policyholder, the beneficiary, heir or liquidator of my estate to provide the Insurance companies, when required by the latter, with all the information and authorizations required for the processing of any claim(s).

I hereby apply for group benefits under my Plan Sponsor's/Employer's plan and authorize any required deductions. I certify that the information given above is true and complete. A photocopy of this authorization is as valid as the original. The original enrolment form will be retained by my Plan Sponsor/Employer.

Employee Signature _____ Date Signed (MM/DD/YY) _____

Part 5: For Plan Administrator/Employer Use Only

Name of Employer / Organization	Employment Type	Division	Class

Employee's Occupation/Position	Annual Earnings	Date of Hire (MM/DD/YY)	Hours Worked Per Week
	$		

Dental (PBC) Effective (MM/DD/YY)	Extended Health (PBC) Effective (MM/DD/YY)	Life (Great West Life) Effective (MM/DD/YY)