PLEASE DO NOT WRITE IN THIS SPACE		
	Eff Date	Group #
Dental		**49243**
EHC		**49243**
Billing		**49243**

PREMIUM HEALTH AND WELFARE PLAN

GROUP INSURANCE APPLICATION- PREMIUM HOUR BANK PLAN

- **Complete this form on date of hire** for a new plan member. Parts 1, 4 and 5 must be completed.
- To submit, MAIL the ORIGINAL completed form to **D.A. Townley 4250 Canada Way, Burnaby, BC V5G 4W6**. You can fax the form for immediate processing to (604) 299-8136, but the original must follow.
- Keep a COPY of this form with the plan member's personnel file.

REASON FOR COMPLETION:

❒ New Plan Member

❒ Re-hire Plan Member - previous plan term date (M/D/Y) ___/___/___

Part 1: Employee & Basic Insurance Information

Employer Group Name				Hiredate (M/D/Y)
Employee's Last Name	First Name	Initial	Phone Number	SIN
Street (Mailing) Address	Phone Number	Birthdate (M/D/Y)		Gender ❒ Male ❒ Female
City	Province Postal Code	Extended Health Coverage Required ❒ Single ❒ Family		Dental Coverage Required ❒ Single ❒ Family

If your spouse is common law indicate the date of cohabitation(M/D/Y): ____/____/____

Definition of spouse: a person of the same or opposite sex who is either married to you or has been living with you for at least 12 months.

Dependent	Dependents Last Name (if different from Employee)	Initial	First Name	Birthdate (M/D/Y)	Relationship	Gender (M/F)	Provide name of school below if child is over 19 and studying full time. If child is disabled to apply for coverage beyond age 19, indicate nature of disability and attach details.
01 Spouse							
02 1st child							
03 2nd child							
04 3rd child							
05 4th child							

Part 2: Spousal or Other Coverage

Are you or your dependents covered for extended health and/or dental benefits by another plan? ___No ___Yes (specify)	Benefit	Name of Carrier	Group Number	Certificate/ID #	Coverage
	Dental:				___Single ___Family
	Health:				___Single ___Family

Part 3: Complete this part if previously covered under the BCCA Group Benefit Plan or the BCCA Health and Welfare Plan with Another Employer

Name of Previous Employer Termination Date (M/D/Y)	Previous Group #	Termination Date (M/D/Y)

PLEASE DO NOT WRITE IN THIS SPACE	Prior Employer Billing No.	Prior Employer Account No.	Billing No.	Account No.

Part 4: Beneficiary Designation

Last Name	First Name	Initial	Share of Proceeds	Relationship to Employee	Name of Trustee for Beneficiaries Under the Age of Majority (18 in B.C.)
			%		
			%		

Part 5: Signature and Authorization

I consent to the collection, use, and exchange of my personal information by my plan sponsor, the administrators of my retirement, savings, and other group benefits programs, the agents retained by my plan sponsor or the administrator, the insurance company providing benefits, and/or other person who requires information for the purpose of retirement, savings, or other group benefits plan administration. I authorize these parties to obtain, and exchange between them, any information about me, my spouse, or my dependent children that they require for the purposes of determining my benefit entitlements, and for record-keeping, file identification, reporting, underwriting, procurement of health information, claims adjudication and resolution, program management, and other services provided to me and my plan sponsor from time to time. I confirm that I have obtained the consent required of my spouse and any dependent children over the age of majority to permit me to give the above consent as it relates to their personal information. I hereby confirm the above beneficiary designation, which replaces any previous revocable beneficiary. I reserve the right to change my revocable beneficiary designation at any time. I hereby apply for group insurance benefits under my plan sponsor's plan and authorize any required deductions. If I should receive a settlement from, or a judgment against, a liable third party for wage loss, extended health, or other benefits covered under my group plan, I agree to and authorize the third party to reimburse the insurance company providing benefits up to the amount of benefits advanced to me pending such settlement or judgment. I authorize the use of my Social Insurance Number for identification purposes.

I understand that my insurance becomes effective provided I have a sufficientof hours banked, and in accordance with the rules of the hour bank plan. I also understand that on the date the insurance of my dependent(s) becomes effective that they cannot be confined to hospital. I certify that the information given above is true and complete.

Employee Signature _____ Date Signed (M/D/Y) _____

Employer Signature _____ Date Signed (M/D/Y) _____