BRITISH COLUMBIA

ENROLLMENT / CHANGE / TERMINATION FOR EXTENDED HEALTH CARE AND DENTAL

Pacific Blue Cross (PBC)

Pacific Blue Cross is the registered trade name of PBC Health Benefits Society

Please type or print clearly in black ink

Do not write in this space

EMPLOYEE ID	SOCIAL INSURANCE NO. (for id purposes only)	**TYPE OF REQUEST** ☐ **New Application** ☐ **Change to Existing Coverage** ☐ **Terminate Employee's Coverage**	TERMINATION DATE YYYY / MM / DD

LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTHDATE YYYY / MM / DD	GENDER ☐ MALE ☐ FEMALE

NAME OF MINISTRY / EMPLOYER	WORK PHONE NO. ( )

HOME ADDRESS – *Must be Completed*	POSTAL CODE	HOME PHONE NO. ( )

FORMER NAME – *Complete if you have changed your name since your initial application*	MEDICAL SERVICES PERSONAL HEALTH NO.

Were you covered within the last 12 months, or are you currently covered, under another Extended Health and Dental Plan (other than Medical Services Plan of BC)? If YES, please provide:

NAME OF INSURANCE COMPANY	GROUP POLICY NO.	I.D. NO.	BENEFITS COVERED UNDER ANOTHER PLAN? ☐ EHB ☐ DENTAL ☐ LTD	IS PLAN ACTIVE? ☐ YES ☐ NO	IF NO, PROVIDE TERMINATION DATE YYYY / MM / DD

ADD / CHANGE / TERMINATE DEPENDENTS

☐ ADD DEPENDENT ☐ CHANGE TO DEPENDENT INFORMATION ☐ TERMINATE DEPENDENT

Complete only if you are adding your spouse

☐ DATE OF MARRIAGE/ ☐ CO-HABITATION YYYY / MM / DD

SOCIAL INSURANCE NO. OF SPOUSE

Complete only if you are terminating coverage for a dependent

Adding or Changing Dependents

1) If adding student age 19 or over, indicate name of school or university attending full time and enrollment date.*
2) If dependent child is handicapped, please confirm that Canada Revenue Agency Form 2201E has been filed and accepted.
3) If adding adopted child or ward, provide date you legally became the child's guardian and attach legal documents.
4) If changing dependent's name, indicate former name.

DEP. NO.	FIRST NAME	INITIAL	LAST NAME (Only if different from employee's)	RELATIONSHIP TO YOU	GENDER M - MALE / F - FEMALE	BIRTHDATE YYYY / MM / DD	TERMINATION DATE YYYY / MM / DD	PERSONAL HEALTH NUMBER	COMMENTS / DETAIL *(Example: School name and term start date)
SPOUSE (01)									
02									
03									
04									
05									

BENEFITS SERVICE CENTRE USE ONLY

DENTAL / EXTENDED HEALTH BENEFIT GROUP NO.	EFFECTIVE DATE OF COVERAGE YYYY / MM / DD	DATE OF EMPLOYMENT YYYY / MM / DD
DATE REQUIRED AUXILIARY HOURS REACHED OR WOULD HAVE BEEN REACHED IF EARLIER THAN THE SIX MONTH WAITING PERIOD	YYYY / MM / DD	DATE EMPLOYEE BECAME REGULAR YYYY / MM / DD

CERTIFICATION – I certify that all statements and answers included on this form are true and complete. By providing my Social Insurance Number, I authorize the insurance carrier to use it for identification purposes only.

INDICATE (✔) IF APPLICABLE:

☐ I am living in a marriage like relationship.

☐ I have care and custody of the dependent children.

☐ My former spouse has care and custody of the above mentioned dependent(s) and is not eligible for extended health or dental coverage.

EMPLOYEE SIGNATURE

X

DATE SIGNED YYYY / MM / DD

Additional information and copies of this form are available on the Internet: www.bcpublicservice.ca/benefits

Benefit Coverage for Your Spouse and Dependents

Employee benefits available to you as an eligible employee of the province can be extended to:

- a married or common-law spouse (same or opposite sex) who is living with you;
- an unmarried child, stepchild, adopted child or legal ward, mainly supported by you, who is a dependent for income tax purposes, and who is:
  - under 19, or
  - under 25 and in full-time attendance at a school, university or vocational institution which provides a recognized diploma, certificate or degree.
  - a dependent child of any age who, because of mental or physical infirmity, is accepted as a dependent for income tax purposes.
- if your dependent children reside with a former spouse and the former spouse is not eligible for coverage under the Extended Health, Dental and Medical Plan of BC, then you may continue coverage under your plan.

Coverage of a common-law spouse – and any eligible dependents – is effective on the date when the employee's coverage is effective, or the first of the month following the date the change application is signed, whichever is later, if:

- you sign the certification that you are living in a common-law relationship; or
- you and your common-law spouse have been co-habiting at least 12 months before your coverage is effective, or
- you and your common-law spouse have been co-habiting less than 12 months prior to your effective date and have claimed your common-law spouse's children for income tax purposes.

Once a common-law spouse has been enrolled in the benefit plan, a different common-law spouse and any eligible dependents may be enrolled in the plan 12 months after you cancel coverage for the previous common-law spouse and applicable dependents.

Adding Dependents

Should an eligible dependent be added after your initial enrollment, coverage begins on the first day of the month following the date the change application is signed.

Coverage for a newborn child is effective from the date of birth. For dependents such as a legal ward or adopted child, a photocopy of court papers or legal documents must be attached to the Enrollment/Change/Termination form. Coverage begins on the date the child legally becomes your ward or child.

Cancelling Spouse

You are responsible for cancelling your spouse when:

- he/she no longer meets the eligibility criteria for common-law spouse; or
- he/she is no longer living with you; or
- you are formally separated; or
- you are divorced.

Cancelling Dependents

You are responsible for cancelling dependent coverage for children who are no longer eligible for coverage as dependents when they:

- marry or live common-law; or
- are no longer supported by you and a dependent for income tax purposes; or
- start full-time employment; or
- reach age of majority, currently set at age 19 for extended health and dental benefits; or
- live with your former spouse and your former spouse is eligible for extended health and/or dental and/or Medical Services Plan coverage.

Coverage can be extended to age 25 for dependents who are full-time students. One month before turning 19, the carrier sends out a new coverage card deleting the dependent. If the dependent is in full-time enrollment in school and is eligible for re-enrollment, advise your employer and complete a change form with the name and birthdate of the child and the institution being attended. Upon receipt of the change form, the dependent will be reinstated and a letter will be sent out every August from the carrier requesting confirmation of the dependent's attendance in school until the dependent has turned 25.

When You Have Completed the Form

Please forward the original Enrollment/Change/Termination form to the Benefits Service Centre, Block E, 2261 Keating Cross Road Saanichton BC V8M 2A5, or fax to 250 652-4882.

Questions?

Contact the Benefits Service Centre toll-free at **1 877 277-0772** if you have any questions.

Freedom of Information and Protection of Privacy Act (FOIPPA)
The personal information requested on this form is collected for the purpose of administering the *Public Service Benefit Plan Act* and is in accordance with the *FOIPPA*. Questions about the use and collection of this information can be directed to the FOI Designate at 250 544-5400, or toll-free at 1 877 277-0772, Telus Sourcing Solutions, Block E, 2261 Keating Cross Road, Saanichton BC V8M 2A5.