

LATE ENROLLMENT - DENTAL

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This form is used by the Payroll & Benefits Office to confirm which coverage you want. Please make sure all applications are dated and signed. If the attached applications are incomplete they will be returned and coverage may be delayed. Please print clearly.

Name: _____ Date: _____

Employee #: _____ School/Location: _____

If you are applying for benefit coverage for any reason other than LATE DENTAL enrollment, please contact the Payroll & Benefits Office for the appropriate forms.

Late applications will be forwarded to Pacific Blue Cross for review. Pacific Blue Cross will determine if you will be approved for coverage. If approved, they will determine the effective date of coverage.





Common Law Spouse Declaration

Employee Common Law Spouse Declaration

(PSOR\HH\1V /DVW 1DPH)LUVW 1DPH

District #

Please insure my common law spouse, _____ for the following benefits _____ :
(full name of common law spouse) (Coverage effective date)

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BenefitsChange Form

Part 1: Employee Identification

First Name	Initial	District #	Employee ID number	Provincial Health Plan Number (Care Card)
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Part 2: Change in Family Status

Change of coverage requested due to: Marriage Cohabitation Divorce Separation Death Birth Adoption Other (specify):

Date of Event (yyyy/mm/dd)

Revised Extended Health Coverage: Single Couple Family Waived (attach Waiver of Coverage form)

Revised Dental Coverage: Single Couple Family Waived (attach Waiver of Coverage form)

Add	Delete	No.	Dependent # (• &] CE • š	Initial	Last Name (if different from Employee)	Birthdate (yyyy/mm/dd)	Relationship	Gender M t Male F t Female X t Another Gender U t Prefer Not to Disclose	Provide name of school and student number if child is over 21 and studying full-time. If child is disabled indicate ^] • o _] v š and attach approved CRA/PWD (Persons with Disability) document if adding an adopted child, provide date of adoption if adding a legal ward, provide court document.
R	R								
R	R								
R	R								
R	R								
R	R								

Part 3: Change to Spousal or Other Coverage

Change of Dental Extended Health coverage requested due to:

Date of Change (yyyy/mm/dd)

CUPE 382 BENEFIT COSTS

Premiums are subject to carrier rate changes

July 2024

		<u>Monthly Premium</u>	<u>Employee Deduction</u>	<u>Board's Share</u>
Extended Health	Single	90.91	0%	90.91 (100%)
	Couple	163.64	0%	163.64 (100%)
	Family	209.09	0%	209.09 (100%)
Dental	Single	71.36	17.84 (25%)	53.52 (75%)
	Couple	140.71	35.18 (25%)	105.53 (75%)
	Family	205.23	51.31 (25%)	153.92 (75%)
Basic Life		.1400 per \$1,000	0%	100%
Basic AD&D		.0070 per \$1,000	0%	100%
Optional Life		individual premiums see brochure for rates	100%	0%
Optional AD&D		individual premiums see brochure for rates	100%	0%

*on a PLOA, or Educ Leave, or Parenthood Leave, or LTD > 2 years, or UnPd Medical Lv > 6 months:
Benefit Premiums are 100% employee paid (Monthly Premium Column)

C U P E 3 8 2 B E N E F I T U

"RNGCUG"MGGR"V J KU"KPHQTOCVKQP"HQT"TGHTGPEG

For benefit information, please visit the following website:

Rwdnke"Gfwecvkqp"Dgpgkhv"Vtwuy"*RGDV+"" " ["y_y_y0rgdv0ec"](#)

CUPE 382 BENEFIT FAQS

WHAT IS MY BENEFIT ELIGIBILITY DATE?

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CUPE 382 BENEFIT FAQs

WHAT IS COVERED UNDER THE EXTENDED HEALTH CARE AND DENTAL PLANS?

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HOW DO I MAKE AN EXTENDED HEALTH CARE CLAIM?

Vjg"Gzvpgpfgf"J gcnvj"Ectg"rncp" kpenwfgu" c"rc{/fktgevn"ftwi"qrvkqp0"Rtgugpv" {qwt"Rcekhke"Dnwg"Etquu"KF"ectf"cv"vjg" r jct o ce{ "cpf" {qwt"r jct o cekuv" y km"uwo kv"vjg"enck o "fktgevn{ "vq"Rcekhke"Dnwg"Etquu0" [qw"qp{ "rc{ "hqt"vjg" c o qwpv"pqv"eqxgtgf"wpfgt"vjg"rncp0" n" cn d w ka" Hqt"cmn"qvjgt"Gc t qwpgc qq o o r ngwg" ewd o gvge c kkttn"

