Plannera
PENSIONS & BENEFITS

☐ Initial Enrolment
◯ Data Change

Return this form
to your department's
Human Resources Branch

Benefit Plan Enrolment Form (Dental & Extended Health Care)

Please complete and return this form to your department's Human Resources Branch.

SECTION A: EMPLOYEE INFORMATION (Please print)			
Last Name	First Name and Initial	Employee Number	
Mailing Address	City	Province	Postal Code
Birthdate (day/month/year)	Gender ☐ Male ☐ Female		

SECTION B: EMPLOYMENT INFORMATION

Employee Type (check one from each category a. and b.):

a) ☐ SGEU ☐ CUPE ☐ Out of Scope

b) ☐ Permanent Full-Time ☐ Labour Service ☐ Permanent Part-Time ☐ Term

If your spouse is currently an employee of Executive Government, please complete this section.

Spouse: Last Name, First Name and Initial	Employee Number	Department ☐ SGEU ☐ CUPE ☐ Out of Scope

SECTION C: SPOUSE/DEPENDENT INFORMATION			
Spouse: Last Name, First Name and Initial	Birthdate (day/month/year)	Gender	
Dependent: Last Name, First Name and Initial	Birthdate (day/month/year)	Gender	☐ Student ☐ Disabled
Dependent: Last Name, First Name and Initial	Birthdate (day/month/year)	Gender	☐ Student ☐ Disabled
Dependent: Last Name, First Name and Initial	Birthdate (day/month/year)	Gender	☐ Student ☐ Disabled

SECTION D: 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.

Signature of Employee

Date (day/month/year)

SECTION E: EMPLOYER USE ONLY

Extended Health Care Plan

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

Public Employees Dental Plan

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

Authorized Signature _____ Date (day/month/year) _____

Employee Enrolment

This form must be returned to your Human Resources Branch for authorization before you are 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 you have been enrolled.

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 per cent 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 stepchild under 21 years of age for whom you are legally and financially responsible;

b) a child or stepchild between the ages of 21 and 25 inclusive, whom you support and who is attending an educational institution on a full time basis (provide verification); or

c) a child or stepchild 21 years of age and over who is solely dependent upon you due to a mental or physical disability (provide verification).

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