

Benefit Plan Enrolment Form (Dental & Extended Health Care)

Please complete and return this form to:

 Human Resource Service Centre
 2100 Broad Street
 Regina SK S4P 1Y5

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				
<p>I certify that the information given is true, correct and complete to the best of my knowledge and promise to immediately notify the Human Resource Service Centre in writing of any change to the employee and/or dependent information indicated above.</p> <p>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.</p>				
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

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- 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 the Human Resource Service Centre for authorization before you are eligible for coverage.

A copy will be returned to you once authorized by the Human Resource Service Centre.

If you do not receive your authorized copy within 31 days, contact the Human Resource Service Centre at 1-877-852-5808 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.