Plannera PENSIONS & BENEFITS

Public Employees Disability Income Plan Enrolment Form

☐ New Member ☐ Change of Name **Reset Form**

SECTION A: EMPLOYEE INFORMATION (Please print)

Employee Last Name	Employee First Name and Initial	Employee Number

Employer Name

SECTION B: ENROLMENT

I understand that I am required to participate in the Disability Income Plan as a condition of my employment, and I hereby:

1) acknowledge that I have received a copy of the Employee Booklet which contains details of the Plan; and
2) authorize my employer to deduct and remit to the Plan any amount which may be required by the Plan to provide coverage to me.

Signature of Employee _____ Date (day/month/year) _____

Signature of Witness _____ Date (day/month/year) _____

When this form is completed and signed, please return the original to your Human Resources Branch.

SECTION C: COMMENTS AND INSTRUCTIONS

1. Participation in the Plan is a condition of your employment.
2. You are covered following three (3) months of continuous employment provided you are actively at work. Deductions begin at this time.
3. The disability benefit is 75 per cent of your basic monthly salary. Full details of the plan are outlined in the Plan Document and Employee Booklet.

The following documents must be submitted when a claim for disability is being made:

1. Disability Income Plan *Enrolment Form*
2. Application for Long-Term Disability Benefits – Employee Statement
3. Application for Long-Term Disability Benefits – Employer Statement
4. Attending Physicians Initial Disability Benefits Statement
5. Job Demands Checklist/Position Description
6. Group Life Insurance Plan *Enrolment Form*