CB Benefits

Canadian Baptist Benefits Plan

Election Form – Benefits Selection

Please print clearly, both sides, in INK – sign and date form. Make a copy for your records.

1. Plan Administrator

Plan Number:	GWL Division Number:	Benefit Class:
Plan Administrator: ❑CBM ❑CBOQ ❑FBU ❑CBWC	Plan Member ID:	
Employer:	Date of Employment (yyyy/mm/dd):	
Effective Date of Coverage (yyyy/mm/dd):	Province of Residence:	Province of Employment:
Occupation:	Earnings: $ per ❑ year ❑ month ❑ week ❑ hour	

2. Member Information

Member's Name (first, middle initial, last):		Gender: ❑ Male ❑ Female
Address (street number and name, apartment or suite):		
City:	Province:	Postal Code:
Date of Birth (yyyy/mm/dd):	Language: ❑ English ❑ French	
Email Address:		
Marital Status: ❑ Single ❑ Married	Family Status for Benefit Coverage: ❑ Member only ❑ Member + 1 ❑ Member + 2 or more	

Spouse Details

Complete this section.	Spouse's Name (first, last):	Date of Birth (yyyy/mm/dd):	Gender: ❑ Male ❑ Female
	Is your spouse covered for health or dental care benefits by his/her employer's plan? ❑ Yes ❑ No Spouse's Insurer:	If yes, please indicate spouse's coverage: Health plan ❑ Family ❑ Single ❑ Vision care Dental plan ❑ Family ❑ Single	

Dependent Children Details

Complete this section. If you have more than three dependents, please photocopy this blank page to include additional details.	Child's Name (first, last):	Date of Birth (yyyy/mm/dd):	Gender:	Student*:	Overage** disabled child:
			❑ Male ❑ Female	❑ Yes ❑ No	❑ Yes ❑ No
			❑ Male ❑ Female	❑ Yes ❑ No	❑ Yes ❑ No
			❑ Male ❑ Female	❑ Yes ❑ No	❑ Yes ❑ No

* A student is a child age 22 or over but under age 25, who is a full-time student attending an educational institution recognized by the CRA, as long as the child is not married or in any other formal union and is entirely dependent on you for financial support.

** To enrol an overage disabled child, contact your plan administrator within 31 days of the date the dependent reaches the age limit (22).

3. Waiver of Health and Dental Benefits

Health and dental benefits can only be waived if you and your dependents have duplicate health coverage (e.g., through a spousal plan). If you wish to waive health and dental coverage under the plan, you may select partial waiver access to the Healthcare Spending Account (HSA) under the Orange Leaf Plan but no other health and dental coverage, or full waiver with no HSA (in Section 4).

Spouse's Insurer: _____ Plan/Policy Number: _____

If you lose spousal coverage, you must apply for coverage under the plan within 31 days of loss of such coverage. If you do not apply within 31 days, you and your dependents may be required to provide proof of insurability acceptable to the insurer to be covered. If you are approved, coverage for dental benefits may be limited. See your plan administrator for details.

4. Flexible Benefits – Great West Life Policy 156241

Your benefit selections will remain in effect until Jan 1 of the next enrolment year, which occurs on even years only (2020, 2022, 2024, etc.).

Choose only *one* plan:
- ❑ Green Leaf Plan
- ❑ Orange Leaf Plan
- ❑ Blue Leaf Plan

- ❑ Full waiver, no HSA
- ❑ Partial waiver, Orange Leaf Plan HSA

5. Optional Life Benefits – Great West Life Policy 156243

Member Optional Life – Units of $10,000 to a maximum of $500,000	Amount Requested: $
Spouse Optional Life – Units of $10,000 to a maximum of $500,000	Amount Requested: $
Optional Child Life – Units of $2,000 to a maximum of $20,000	Amount Requested: $

You must provide evidence of insurability for Optional Life Insurance and Spousal Optional Life Insurance in excess of any amounts you currently have. Your plan administrator will forward the required form for you to complete and return to the Great-West Life office. No additional coverage will be in effect until approved by the insurer.

6. Optional Accidental Death & Dismemberment Insurance – CHUBB Policy OE1058101

Units of $10,000 to a maximum of $250,000	Amount Requested: $

Choose only *one* plan:
- ❑ Member Only
- ❑ Member + Dependents

No evidence of insurability is required for Optional Accidental Death & Dismemberment Insurance.

7. Optional Critical Illness Insurance – Great West Life Policy 156243

Member Critical Illness – Units of $5,000 to a maximum of $150,000	Amount Requested: $
Spouse Critical Illness – Units of $5,000 to a maximum of $150,000	Amount Requested: $

You must provide evidence of insurability for Optional Critical Illness Insurance for amounts over $25,000. If applying for coverage over $25,000, your plan administrator will forward the required form for you to complete and return to the Great West Life office specified. No coverage in excess of $25,000 will be in effect until approved by the insurer.

Privacy, Authorizations, Declarations

The personal information the plan administrator collects concerning you and your dependents is kept in strict confidence and used only for the purposes you have authorized. Your personal file is kept at the plan administrator's offices. You have the right to request access to your personal information, and, if necessary, correct any inaccurate information and/or make changes to current information whenever necessary. In order to do so, send a written request to the plan administrator.

Access to your personal information will be limited to the plan administrator and insurers in the performance of their jobs, individuals to whom you have consented access, and persons authorized by law. For the purposes of audits and administrative reporting, the plan administrator may release your Employer/Policyholder statistical information without personal identifiers.

I HEREBY APPLY for the benefits which I am or may become eligible for, subject to any waiver indicated, under my Employer's/Policyholder's group insurance plan and CONFIRM that the information contained in this form is true and complete to the best of my knowledge.

If any contributions are required to be made by me with respect to my group benefits, I AUTHORIZE my employer to make any required deductions from my earnings and remit same to the applicable insurance provider.

I AGREE that a photocopy of this Confirmation/Authorization shall be as valid as the original.

Plan Member's Signature X	Date (yyyy/mm/dd)
Plan Member's Name (please print)	