Catholic Independent Schools of Vancouver Archdiocese in Association with
Great-West Life Assurance Company - Policy No's. 335645, 335646 & 56565 / Division: 10

APPLICATION FOR GROUP BENEFIT COVERAGE

Mandatory Participation required for all eligible employees

Instructions: **1)** Please print all information clearly in *blue* or *black* ink.
2) Employer to forward **original** to Benefit Administration Office and keep second copy.

1. Policyholder Section - To be completed by **Benefit Representative**. Select ☑ the appropriate Benefit Class.

☐ Class 1: Permanent Employees ☐ Class 2: 1 year – Contract Employees ☐ Class 4: Priests

☐ Class 8: All Other Employees (ie: non-salary, religious) ☐ Class 100: Pension only for PT employee's under 20 hrs/week but earn no less than 35% of CCRA's, Years Maximum Pensionable Earnings (YMPE). Must have been employed with the employer for 2 consecutive years.

School/Parish (ER): _____ Division/ER No.:___

Employee ID number: _____ SIN: _____
(to be assigned by the *Benefit Administration Office*)

Date of employment: Month _____ Day _____ Year _____

Effective date of coverage: Month _____ Day _____ Year _____

Probation Period Applied?
If "yes", how long?
_____ months
(Teachers are not subject to a probation period)

Late Applicant? ☐ Yes **OR** ☐ No | Identified as: ☐ Catholic **OR** ☐ Non-Catholic

Occupation: _____ | Gross Annual Earnings: $ _____ (must be reflected as an annual salary)

No. of **hours** worked per week: _____
(minimum 20 hour work-week requirement for coverage of employer group benefits)

No. of **days** worked per week: _____

No. of **weeks** worked per year : _____
(ie: 43, 48, 52 Minimum no. of weeks is 43. For the purpose of GWL disability)

Income earned/paid within the month of the **Effective date of coverage**
(This is only applicable to those employees who are insured *after* the 1st calendar day of the month AND will be contributing to Pension)
$ _____

2. Employee Information - To be completed by **Employee**.

Employee name (print):_____
(First Name) (Middle Initial) (Last Name)

Gender: ☐ Male ☐ Female Date of birth: Month _____ Day _____ Year _____

Mailing address: _____

City: _____ Province: _____ Postal Code: _____

Phone Number: (_____)_____ Cellular Phone Number: (_____)_____

Do you have a spouse (legally married)? ☐Yes ☐No

Do you have dependent children, including full-time students or disabled adults? ☐Yes ☐No

3. Beneficiary Designation - To be completed by those Employees who are eligible for the Life Insurance benefit. You **MUST** complete a "Trustee Appointment" form when designating a minor (age 19 and younger) as your beneficiary.

A beneficiary must be designated for your Life Insurance benefit, if applicable. Your beneficiary(s) are listed as **Revocable.** and can be changed at any time.

Last Name	First Name	Relationship	Distribution %	Gender	Minor
				☐ Male ☐Female	☐Yes ☐No
				☐ Male ☐Female	☐Yes ☐No
				☐ Male ☐Female	☐Yes ☐No
				☐ Male ☐Female	☐Yes ☐No
			Total 100%		

Contingent beneficiary(ies) – If all of the above beneficiaries die before me, the Life benefit set out in the group policy is to be paid to:

Last Name	First Name	Relationship	Distribution %	Gender	Minor
				☐ Male ☐Female	☐Yes ☐No
				☐ Male ☐Female	☐Yes ☐No
				☐ Male ☐Female	☐Yes ☐No
				☐ Male ☐Female	☐Yes ☐No
			Total 100%		

4. **Registered Pension Plan (RPP) –** To be completed by eligible Benefit Class 1, 2, 4 and 100 Employee's only.
NOTE: It is not mandatory to enroll in the Registered Pension Plan; however, once you have enrolled, you CANNOT opt-out.

☐ No, at this time I choose to opt-out of the RPP program; or

☐ Yes, I would like to enroll in the RPP program. I understand that while employed, I cannot withdraw from or terminate my RPP contributions. My Employer-matched contribution level will be (choose one):

☐ 3% **OR** ☐ 7%

☐ My **Voluntary** Pension contribution will be: $ _____ per month (Vol. pension contributions are **not** matched by the ER)

5. **Refusal of Benefits -** To be completed by Employee. **Important:** Extended Health and/or Dental benefits are the **only** benefits that can be refused providing you and/or your dependents are covered by duplicate group benefits through your spouse's employer.

I understand the plan of group benefits offered to me, but **decline** to participate in: (Employee **MUST** complete this section if they want to waive the extended health and/or dental. Spouse's plan **MUST** be provided. If the information is NOT provided, your Extended Health and/or Dental coverage will **NOT** be waived.)

Extended Health benefits for: ☐ myself and my dependents ☐ my dependents only

Dental benefits for: ☐ myself and my dependents ☐ my dependents only

Spouse's Insurance carrier _____ Their policy number: _____

6. **Dependent Information –** To be completed by **Employee** if there is **a Family Extended Health and/or Dental benefit**.

Spouse's Information (please print)**:**

_____
Last Name First Name Middle Initial

Date of Birth: Month _____ Day _____ Year _____

Gender: ☐Male ☐Female

List benefits covered through your spouse's employer plan:

Extended Health Benefits		Dental Benefits	
☐Single	☐Family	☐Single	☐Family
☐Waived	☐None	☐Waived	☐None

Where applicable, benefit payments will be coordinated between this plan & your spouse's.

Dependent Children Information:

			Date of Birth: Month /Day/ Year	Gender M	Gender F	Post Secondary Student?	Disabled Dependent Yes
Last Name	First Name	Middle Initial					
Last Name	First Name	Middle Initial					
Last Name	First Name	Middle Initial					
Last Name	First Name	Middle Initial					
Last Name	First Name	Middle Initial					

Indicate post-secondary school the dependent student(s) is attending: _____

7. **Authorizations and Declarations -** I hereby apply for coverage under the group benefits plan issued by Great-West Life. I authorize:
- My employer to deduct from my pay and remit to Great-West Life the plan member contributions required under the plan, if applicable;
- Great-West Life to use my social insurance number for tax reporting purposes and as an identification number where it is required in the administration of the plan;
- Great-West Life, any healthcare provider, my Benefit Representative at the local level, the Benefit Administration Office, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life to exchange personal information, when necessary to determine my eligibility for coverage and to administer the plan.

If applying for coverage for my spouse and/or dependents, I confirm that I am authorized to act on their behalf. I agree that a photocopy or electronic copy of this Authorizations and Declarations section is as valid as the original.

I certify that the information given is true, correct and complete to the best of my knowledge.

Employee signature: _____ **Date:** _____

- **Employer signature:** _____ **Date:** _____

(Received by CISVA – Benefit Administration Office: _____**)**