

**INSURED BENEFIT PROGRAMS  
GUIDE FOR ACTIVE EMPLOYEE ENROLMENTS OR CHANGES**

**\*\*TIME SENSITIVE - ACTION REQUIRED\*\***

**PLEASE READ CAREFULLY BEFORE COMPLETING THE FORM**

Complete, date and sign this form to enrol or change your existing coverage in the Government of New Brunswick's Employee Benefit Programs.

**Enrolment**

- Verify that you and your family members meet the definitions of those eligible to participate in the Employee Benefit Plans by reviewing the [Eligibility Criteria Benefit Fact Sheet](#).
- Once you've fully completed the applicable section(s) and signed the form(s), they must be sent to your employer **within 31 days of becoming eligible to participate**.

**Changing Coverage**

- If you are actively at work (capable of working your regular schedule) and would like to make changes to your coverage, you **MUST** do so within 31 days following an eligible life changing event (see list below).

If you are on an approved leave of absence from work, you **MUST** submit your change(s) within 31 days of the date you return to work. There are provisions that allow employees on an approved leave to change their coverage within 31 days following the life changing event if:

- 1) The employee is on maternity/paternity or adoption leave and continued coverage during their leave; or
- 2) The employee involuntarily lost coverage under a spousal plan.

- For the following life changing events, your employer will need to see proof of Medicare coverage (i.e. Medicare card), along with the following documentation, as it becomes available:

Life Changing Event	Who can be added?	Documentation Required
Marriage	Spouse & his/her eligible dependent children	Marriage certificate
Common-Law	Spouse & his/her eligible dependent children	<a href="#">Statutory Declaration of Common-Law Partner form</a>
Birth or Adoption	Newborn or Adopted child	Birth certificate or Legal Adoption papers
Divorce/Separation	Dependent Children	Divorce Judgment or Separation Agreement
Death of a Spouse	Dependent Children	Death Certificate
Involuntary loss of Employee's coverage through spouse's plan	Employee, spouse & eligible dependent children	Applies to health and/or dental coverage only. Proof of termination of similar coverage from employer or insurance provider (including date coverage terminated, description of coverage and confirmation of who was covered).

**Late Applicant**

If you and/or your eligible dependents do not enrol in the Employee Benefits Plans **within 31 days** of becoming eligible to participate or change your coverage, you and/or your eligible dependents will be considered a [Late Applicant](#).

**For more information visit [www.vestcor.org/employeebenefits](http://www.vestcor.org/employeebenefits) where you will find the following:**

- The Eligibility Criteria Benefit Fact Sheet which describes who is eligible to participate and the requirements that must be met.
- The Benefit Fact Sheet for Late Applicant which describes the Late Applicant provision and the associated risks.
- The Statement of Health for Late Applicant
- Employee Benefit pamphlets which include coverage details such as eligible products or services and benefit maximums
- And much more!

**If you have any questions, contact Vestcor's  
Member Services team at (506) 453-2296 or 1-800-561-4012.**

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**SECTION A TO BE COMPLETED BY EMPLOYEE**

Enrolment                       Change Coverage                       Late Application – Attach completed [Statement of Health](#)  
**REQUESTING:**     Transfer Coverage                       Change Beneficiary                       Other \_\_\_\_\_  
 Terminate/Cancel Coverage                       Change Name

Last Name of Employee	First Name	Middle Initial	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (DD-MM-YY)	Social Insurance Number
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**SELECT COVERAGE OPTIONS**

**1. BASIC LIFE AND EQUAL AMOUNT OF ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)** (Compulsory)                       1 X annual salary

**2. OPTIONAL LIFE AND EQUAL AMOUNT OF AD&D** (Optional)                       Decline     Cancel  
 1 X annual salary  
 2 X annual salary  
 3 X annual salary  
 4 X annual salary  
Applicable to Judges only {

**3. VOLUNTARY AD&D** (Optional)     Decline                       Single     Family    Principal Sum \$ \_\_\_\_\_ (units of \$10,000 up to \$500,000)  
 Cancel

**4. DEPENDENT LIFE** (Optional)     Yes                       Decline                      **NOTE: Beneficiary is the Employee**  
 Cancel

**5. LONG TERM DISABILITY (LTD)** (Compulsory for eligible groups)     Enrol     Not Eligible                       Missed Enrolment (up to 12 months retro premium required)  
 Late Application -- Complete Statement of Health for LTD

**6. HEALTH** (Optional)                       Yes                       Decline                       Change    **If Yes or Change complete section C on page 2**  
 Cancel

**7. DENTAL** (Optional)                       Yes                       Decline                       Change    **If Yes or Change complete section C on page 2**  
 Cancel                      **Note: If yes, 2 year minimum participation required.**

**BENEFICIARY DESIGNATION FOR BASIC LIFE, OPTIONAL LIFE AND VOLUNTARY AD&D**

**8. NAME YOUR BENEFICIARY(IES) BELOW AND CHECK THE BENEFIT BOX(ES) THAT IT APPLIES TO:**

Basic Life	Optional Life	Voluntary AD&D	Beneficiary (First and Last Name)	Date of Birth <sup>1</sup> (DD-MM-YY)	Relationship to employee	Percentage of benefit paid (must total 100%)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____

<sup>1</sup> If any beneficiary(ies) listed above are considered a minor, designate a trustee to receive and disburse any moneys payable under the above mentioned group policy(ies) during their minority. Not applicable in Quebec.

_____	(____)	_____
<b>Trustee's first and last name</b>	<b>Relationship to employee</b>	<b>Telephone Number</b>

**9. DECLINE/CANCEL OPTIONAL BENEFITS:** I have read the [Late Applicant Benefit Fact Sheet](#) and understand that by electing to decline or cancel any of the above optional benefits, my dependents and I may be considered Late Applicant(s) and I am aware of the associated risks if I (we) wish to enrol at a later date.

**10. AUTHORIZATION:** I certify that the information above is accurate and authorize payroll deductions, if required. By providing my Social Insurance Number, I authorize the insurance carrier; plan administrator and the pay & benefits administrator to use it for identification purposes only.

Signature of Employee: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\* EMPLOYEE: FORWARD TO EMPLOYER (HUMAN RESOURCES OR PAYROLL SERVICES) \*\***

**SECTION B TO BE COMPLETED BY EMPLOYER (HUMAN RESOURCES OR PAYROLL SERVICES)**

Name of Employer	Hire Date (DD-MM-YY):	Effective Date of Coverage or Change (DD-MM-YY):
Employment Type (check one) <input type="checkbox"/> Full time <input type="checkbox"/> Part time - hrs/wk _____	Employment Status (check one) <input type="checkbox"/> Permanent <input type="checkbox"/> Seasonal <input type="checkbox"/> Casual <input type="checkbox"/> Temporary/Term <input type="checkbox"/> Other _____	
<input type="checkbox"/> Bargaining <input type="checkbox"/> Non-Bargaining	Name of Bargaining Group (if applicable)	

Signature of Employer: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\* EMPLOYER: FORWARD TO VESTCOR \*\***

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**SECTION C TO BE COMPLETED BY EMPLOYEE IF ENROLING OR CHANGING HEALTH AND/OR DENTAL COVERAGE**

**REQUESTING:**    Enrolment    Change Address/Telephone    Change Coverage    Late Application – [Attach Statement of Health form](#)  
 Change Name    Change Dependents    Transfer Coverage (ACTIVE) <sup>1</sup>    Other \_\_\_\_\_

<sup>1</sup> Medavie Blue Cross Identification #	Enrol/Add	Change	Single	Family
(11 digits):	HEALTH & TRAVEL <input type="checkbox"/>	<input type="checkbox"/>	HEALTH & TRAVEL <input type="checkbox"/>	<input type="checkbox"/>
	DENTAL <input type="checkbox"/>	<input type="checkbox"/>	DENTAL <input type="checkbox"/>	<input type="checkbox"/>

**EMPLOYEE INFORMATION**

Last Name of Employee \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Date of Birth (DD-MM-YY) \_\_\_\_\_  
 Male    Female   Telephone Number (   ) -

Language Preference   Address (Street & No.)   City or Town   Province   Postal Code  
 English    French

**DEPENDENT INFORMATION (FOR FAMILY COVERAGE ONLY)**

Enrol Add	Change Name	Remove	Last Name	First Name	Initial	Gender M/F	Date of Birth (DD-MM-YY)	If Dependent Child is age 21 or older
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spouse					Full-time Student   Special Dependent
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Children					<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/> <input type="checkbox"/>

**COMPLETE IF DEPENDENT CHILD IS 21 YEARS OF AGE OR OLDER**

**If Full-Time Student:**   Name of accredited school, college or university \_\_\_\_\_ School Term (DD-MM-YY) \_\_\_\_\_  
From: \_\_\_\_\_ To: \_\_\_\_\_

**If Special Dependent:**   Coverage is subject to approval by Medavie Blue Cross (MBC). The [Special Dependent Questionnaire](#) located at <https://www.medaviebc.ca/en/resources> must be completed and emailed, mailed or faxed to MBC.

**COMPLETE IF ENROLING/ADDING A SPOUSE**

If married, provide date of marriage (DD-MM-YY): \_\_\_\_\_ If common-law, provide date co-habitation began (DD-MM-YY): \_\_\_\_\_

**PRIVACY CONSENT:** I understand that the personal information provided herein, as well as any other personal information currently held or collected in the future by Medavie Blue Cross and/or Blue Cross Life Insurance Company of Canada, may be collected, used, or disclosed to administer the terms of my policy or the group policy of which I am an eligible member, to recommend suitable products and services to me, and to manage Blue Cross's business. Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These third parties include other Blue Cross organizations, health care professionals or institutions, life and health insurers, government and regulatory authorities, and other third parties when required to administer and manage the benefits outlined in the policy of which I am an eligible member. I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time, however, in some instances doing so may prevent Blue Cross from providing me with the requested coverage or benefits. I understand why my personal information is needed and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure. A photocopy of this authorization shall be as valid as the original. This consent complies with federal and provincial privacy laws. For additional information regarding privacy policies at Medavie Blue Cross, visit [www.medavie.bluecross.ca](http://www.medavie.bluecross.ca) or call 1-800-667-4511.

**AUTHORIZATION:** I certify that the information above is accurate and authorize payroll deductions, if required. I authorize Blue Cross to collect, use and disclose my personal information as described in the Privacy Consent section above.

**Signature of Employee:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**\*\* EMPLOYEE: FORWARD TO EMPLOYER (HUMAN RESOURCES OR PAYROLL SERVICES) \*\***

**SECTION D TO BE COMPLETED BY EMPLOYER (HUMAN RESOURCES OR PAYROLL SERVICES)**

Name of Employer <b>PROVINCE OF NEW BRUNSWICK</b>	Name of Department, Health Authority, School District, etc.	Payroll No. (max. 9 positions)
Hire Date (DD-MM-YY)	Effective Date of Coverage or Change (DD-MM-YY)	Policy & Section #
		Employee's Identification #

**Note:** If employee is adding a full-time student age 21 or older, the employer must update status information or request new identification cards by visiting the [Group Administrator Site](#) at <http://web.medavie.bluecross.ca/en/linked/group-administrators> or submit by email, mail or fax to Medavie Blue Cross.

**Signature of Employer:** \_\_\_\_\_ **Date (DD-MM-YY):** \_\_\_\_\_

**\*\* EMPLOYER: FORWARD TO MEDAVIE BLUE CROSS (MBC) OR  
KEEP THIS FORM FOR YOUR FILE IF ENTERED VIA GROUP ADMINISTRATOR SITE\*\***

MBC: 644 Main Street, P.O. Box 220, Moncton, NB E1C 8L3  
Tel: 1-800-667-4511 Fax: (506) 869-9653; Email: [BC\\_CustSupp\\_EnrollmentDart@medavie.bluecross.ca](mailto:BC_CustSupp_EnrollmentDart@medavie.bluecross.ca)