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 (dependents) meet the definitions of those eligible to participate in the Employee Benefit Plans by reviewing the Eligibility Criteria Benefit Fact Sheet. A dependent is your spouse and/or children.
- 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.**
- Failure to select an applicable coverage option for each benefit means that you have not authorized premium deductions for that benefit and therefore you do not have coverage.

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.
- 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	Statutory Declaration of Common-Law Partner form
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	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 where you will find the following:

- The Eligibility Criteria Benefit Fact Sheet: describes who is eligible to participate and the requirements that must be met;
- The Benefit Fact Sheet for Late Applicant: describes the Late Applicant provision and the associated risks;
- The Statement of Health for Late Applicant;
- Employee Benefit pamphlets: 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.

INSURED BENEFIT PROGRAMS
ACTIVE EMPLOYEE ENROLMENT/CHANGE FORM

New Nouveau Brunswick

SECTION A TO BE COMPLETED BY EMPLOYEE

REQUESTING:
☐ Enrolment ☐ Change Coverage ☐ Late Application – Attach completed Statement of Health
☐ Transfer Coverage ☐ Change Beneficiary ☐ Other _____
☐ Terminate/Cancel Coverage ☐ Change Name

Last Name of Employee	First Name	Middle Initial	☐ Male ☐ Female	Date of Birth (DD-MM-YY)	Social Insurance Number

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
   Applicable to Judges only: ☐ 3 X annual salary ☐ 4 X annual salary

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

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

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 ☐ Cancel ☐ Change **If Yes or Change complete section C on page 2**

7. **DENTAL** (Optional) ☐ Yes ☐ Decline ☐ Cancel ☐ Change **If Yes or Change complete section C on page 2** **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[1] (DD-MM-YY)	Relationship to employee	Percentage of benefit paid (must total 100%)
☐	☐	☐				
☐	☐	☐				
☐	☐	☐				
☐	☐	☐				

[1] 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.

_____ _____ (____)_____
Trustee's first and last name **Relationship to employee** **Telephone Number**

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): ☐ Full time ☐ Part time - hrs/wk _____

Employment Status (check one): ☐ Permanent ☐ Seasonal ☐ Casual ☐ Temporary/Term ☐ Other _____

☐ Bargaining ☐ Non-Bargaining — Name of Bargaining Group (if applicable)

Signature of Employer: _____ **Date:** _____

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

INSURED BENEFIT PROGRAMS
ACTIVE EMPLOYEE ENROLMENT/CHANGE FORM

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) [1] ☐ Terminate/Cancel Coverage ☐ Other _____

[1] Medavie Blue Cross Identification #		Enrol/Add	Change	Employee Only	Employee +1 dependent	Employee +2 or more dependents
(11 digits):	HEALTH & TRAVEL	☐	☐	☐	☐	☐
	DENTAL	☐	☐	☐	☐	☐

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: Full-time Student	Special Dependent
☐	☐	☐	Spouse						
☐	☐	☐	Children					☐	☐
☐	☐	☐						☐	☐
☐	☐	☐						☐	☐

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 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 **PROVINCE OF NEW BRUNSWICK**	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: MAAX.Policy.Administrators@medavie.bluecross.ca