INSURED BENEFITS PLANS
ACTIVE EMPLOYEE ENROLMENT/CHANGE FORM

GUIDE TO COMPLETE THE ENROLMENT/CHANGE FORM FOR ACTIVE EMPLOYEES

****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 GNB Employee Benefit Programs.

- To enrol as a new employee, verify that you and your family members (dependents) meet the definitions of those eligible to participate in the Employee Benefit Plans by reviewing the **Benefit Fact Sheet – Eligibility Criteria**. A dependent is your spouse and/or children. You **MUST** submit an Enrolment/Change Form within **31 calendar days of your eligibility date**.
- To enrol and/or make changes to your existing coverage due to a Life Changing Event **while you are actively at work**, you **MUST** submit an Enrolment/Change Form within **31 calendar days of experiencing the Life Changing Event** (see the table below).
- If the Life Changing Event happens **while you are on an approved leave of absence**, you will have **31 calendar days of the date you return to work** to submit an Enrolment/Change Form to enrol and/or make changes to your existing coverage. There are **exceptions** for the two Life Changing Events detailed below.
    - **Birth or Adoption:**
        - If you continued coverage during your maternity/paternity or adoption leave, you have 31 calendars days from the birth or adoption date to add dependents and/or make changes to your existing coverage. If the 31-calendar day timeline is missed, you will have to wait upon your return to work to submit a late application to enrol/make changes to your existing coverage. No late application will be accepted while on a leave of absence.
        - If you did not continue coverage or did not have coverage prior to this Life Changing Event, you will have 31 calendar days from the date you return to work to enrol, add dependents and/or make changes to your existing coverage.
    - **Involuntary Loss of Coverage:**
        - If you and/or your dependents involuntarily lose Health and/or Dental coverage, while you are on an approved leave of absence, you have 31 calendar days from the date in which you lost coverage to enrol and/or make changes to your existing coverage. If the 31 calendar day timeline is missed, you will have to wait upon your return to work to submit a late application to enrol/make changes to your existing coverage. No late application will be accepted while on a leave of absence.
- To enrol in the Health, Travel and/or Dental Plans, **proof of a provincial or territorial government health insurance** coverage is required (e.g., Medicare Card).

IMPORTANT - When completing the form, if you leave an optional coverage section blank without indicating it as "Declined", we will process the form as submitted and will interpret it as a decision not to elect that coverage. If you do not enrol or make changes within 31 calendar days of becoming eligible, you will be considered as a **Late Applicant** and may be at risk of being declined coverage by the Insurer.

- Once you've fully completed the applicable section(s) and signed the form(s), they must be sent to your employer **within 31 calendar days of your eligibility date.**

NOTE: If you cannot obtain the documentation required within **31 calendar days**, send the enrolment form to your employer immediately and then send the required documentation when it becomes available.

Life Changing Event	Who can be added?	Documentation Required
1. Marriage 2. Common Law Partnership	Employee, Spouse, and Dependent Children	1. Copy of the marriage certificate/statement. 2. The **Statutory Declaration of Common-Law Partner**. **IMPORTANT:** The addition of a common law spouse can only be made within 31 calendar days following one year of cohabitation.
1. Birth 2. Adoption	Employee, Spouse, and Dependent Children	1. Copy of the birth certificate. 2. Copy of the sealed signed adoption documents.
1. Divorce 2. Separation	Employee and Dependent Children	1. Copy of the divorce judgment. 2. Copy of the separation agreement.
Death of a Spouse	Employee and Dependent Children	Copy of the death certificate.
Initial Post-Secondary Enrolment	Dependent Children	Applies to the student's initial enrolment in post secondary education. Proof of full-time enrolment in an accredited post-secondary institution.
Involuntary loss of coverage	Employee, Spouse, and 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).
Obtaining of Government Health Insurance (e.g. Medicare)	Employee, Spouse, and Dependent Children	Proof of acceptance for Government Health Insurance - eligibility confirmation letter which includes the effective date of coverage.

For a full explanation of each life-changing event, including the conditions and exclusions associated with each, refer to page 4 of the **Active Employee Benefits Booklet**.

For more information visit www.gnb.ca/employeebenefits where you will find the Active Employee Benefit Booklet and Fact Sheets.

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

INSURED BENEFITS PLANS
ACTIVE EMPLOYEE ENROLMENT/CHANGE FORM

SECTION A TO BE COMPLETED BY EMPLOYEE

REQUESTING:

- ☐ Enrolment
- ☐ Change Coverage
- ☐ Late Application – Attach completed Statement of Health
- ☐ Life Changing Event – Attach required documentation *(refer to the table on page 1)*
- ☐ Change Name
- ☐ Change Address/Telephone
- ☐ Transfer Coverage *(Active Employee)*
- ☐ Other _____

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

**Male/Female – Means sex at birth. Why do we ask? The insurance industry predicts benefit usage based on sex. However, we recognize that your sex may differ from your gender identity.*

Telephone Number ( ) -	Email

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

Applicable to Judges only:
- ☐ 1 X annual salary
- ☐ 2 X annual salary
- ☐ 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. OPTIONAL CRITICAL ILLNESS *(Optional)*
To enrol in the Optional Critical Illness benefit, visit www.medaviebc.ca/optional/gnb. To make changes to coverage, call Medavie Blue Cross' Optional Benefits Team at 1-844-949-3809.

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

6. LONG TERM DISABILITY (LTD) *(Compulsory for eligible groups)*
☐ Enrol ☐ Not Eligible
*** To find out if you belong to an eligible group, contact your employer (Human Resources or Payroll Services).**

7. HEALTH *(Optional)*
☐ Yes ☐ Decline ☐ Cancel ☐ Change
If Yes or Change complete section C on page 3

8. DENTAL *(Optional)*
☐ Yes ☐ Decline ☐ Cancel ☐ Change
If Yes or Change complete section C on page 3
Note: If yes, 2-year minimum participation required.

BENEFICIARY DESIGNATIONS AND CHANGES

9. To designate beneficiaries for the Basic Life / AD&D, Optional Life / AD&D, and Voluntary AD&D benefits, you must complete a Beneficiary Designation/Change Form and forward to Vestcor. Note that for the Dependent Life benefit, the beneficiary is the employee.

AUTHORIZATION

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

11. 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 (DD-MM-YY): _____

**** 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)*: _____

For digital signatures only

I, _____, hereby declare that I have validated the authenticity of the employee's digital signature.

Signature of Employer: _____ Date (DD-MM-YY): _____

*** EMPLOYER: FORWARD TO VESTCOR ****
P.O. Box 6000, Fredericton, NB E3B 5H1
Tel: 1-800-561-4012; Fax: (506) 457-7388; Email: info@vestcor.org

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INSURED BENEFITS PLANS
ACTIVE EMPLOYEE ENROLMENT/CHANGE FORM

New Nouveau Brunswick

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

REQUESTING: ☐ Enrolment ☐ Change Coverage ☐ Change Dependents ☐ Late Application – Attach completed Statement of Health
☐ Life Changing Event – Attach required documentation *(refer to the table on page 1)* ☐ Change Name ☐ Change Address/ Telephone ☐ Combining two employee plans[2]
☐ Transfer Coverage (Active Employee)[1] ☐ Terminate/Cancel Coverage ☐ Other _____

MEDAVIE BLUE CROSS IDENTIFICATION # (11 DIGITS)	HEALTH	DENTAL **Note:** 2-year minimum participation required.
[1]For transfer:	☐ Enrol/ Add ☐ Change ☐ Employee Only ☐ Employee + 1 dependent ☐ Employee + 2 or more dependents	☐ Enrol/ Add ☐ Change ☐ Employee Only ☐ Employee + 1 dependent ☐ Employee + 2 or more dependents
[2]For combining – ID # of spouse:		

EMPLOYEE INFORMATION

Last Name of Employee	First Name	Initial(s)	Date of Birth (DD-MM-YY)	☐ Male* ☐ Female*	Telephone Number ( ) -

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

**Male/Female – Means sex at birth. Why do we ask? The insurance industry predicts benefit usage based on sex. However, we recognize that your sex may differ from your gender identity.*

DEPENDENT INFORMATION (FOR FAMILY COVERAGE ONLY)

Enrol/ Add	Change Name	Remove	Last Name	First Name	Initial	M/F	Date of Birth (DD-MM-YY)	If Dependent Child is age 21 or older: Full-time Student	If Dependent Child is age 21 or older: Special Dependent
☐	☐	☐	Spouse						
☐	☐	☐	Children					☐	☐
☐	☐	☐						☐	☐
☐	☐	☐						☐	☐

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):

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 www.medaviebc.ca/en/resources must be completed and emailed, mailed or faxed to MBC.	

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 (DD-MM-YY):** _____

**** 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. 9characters)*
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 www.medavie.ca/en/administrators or submit by email, mail or fax to Medavie Blue Cross.

For digital signatures only

I, _____, hereby declare that I have validated the authenticity of the employee's digital signature.

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