

**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 (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 [Eligibility Criteria Benefit Fact Sheet](#). 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** (capable of working your regular schedule), you **MUST** submit an Enrolment/Change Form within **31 calendar days of experiencing the Life Changing Event** (see the table below).
- To enrol and/or make changes to your existing coverage due to a Life Changing Event **while on an approved leave of absence**, you **MUST** submit an Enrolment/Change Form within **31 calendar days of the date you return to work**. 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 calendar days** from the birth or adoption date to add dependents and/or make changes to your existing coverage.
 - 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 lost Health and/or Dental coverage, you have **31 calendar days** from the date in which you lost coverage to enrol and/or make changes to your existing coverage.
- 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**. Proof of government health insurance coverage (e.g. Medicare Card) must be attached with this form.
- **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.

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
Marriage or Common-Law Partnership*	Employee, Spouse, and Dependent Children	Marriage Certificate or Statutory Declaration of Common-Law Partner form
Birth or Adoption	Employee, Spouse, and Dependent Children	Birth Certificate or Adoption papers
Divorce or Separation*	Employee and Dependent Children	Divorce Judgment or Separation Agreement
Death of a Spouse	Employee and Dependent Children	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 (card or eligibility confirmation letter).

**Can only take advantage of one or the other, not both. For example, if a couple who attains common-law status and later gets married, the marriage would only be considered a Life Changing Event if the couple did not take advantage of the common-law status Life Changing Event (e.g., did not enrol or make changes upon attaining common-law status). The same interpretation applies for separation and divorce.*

Late application to enrol or change your coverage

If you and/or your eligible dependents do not enrol in or make changes within **31 calendar days** of becoming eligible to participate or experience a Life Changing Event, you and/or your dependents will be considered a [Late Applicant](#) and may be at risk of being declined coverage by the Insurer.

For more information visit vestcor.org/benefits 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 BENEFIT PROGRAMS
ACTIVE EMPLOYEE ENROLMENT/CHANGE FORM**



SECTION A TO BE COMPLETED BY EMPLOYEE

REQUESTING:	<input type="checkbox"/> Enrolment	<input type="checkbox"/> Change Coverage	<input type="checkbox"/> Late Application – Attach completed Statement of Health
	<input type="checkbox"/> Life Changing Event – Attach required documentation (refer to the table on page 1)	<input type="checkbox"/> Change Name	<input type="checkbox"/> Change Address/Telephone
	<input type="checkbox"/> Transfer Coverage (Active Employee)	<input type="checkbox"/> Terminate/Cancel Coverage	<input type="checkbox"/> Other _____

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

1. BASIC LIFE AND EQUAL AMOUNT OF ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) (Compulsory)	<input checked="" type="checkbox"/> 1 X annual salary
2. OPTIONAL LIFE AND EQUAL AMOUNT OF AD&D (Optional)	<input type="checkbox"/> Decline <input type="checkbox"/> Cancel <input type="checkbox"/> 1 X annual salary <input type="checkbox"/> 2 X annual salary <input type="checkbox"/> 3 X annual salary <input type="checkbox"/> 4 X annual salary
3. VOLUNTARY AD&D (Optional)	<input type="checkbox"/> Decline <input type="checkbox"/> Single <input type="checkbox"/> Family Principal Sum \$ _____ (units of \$10,000 up to \$500,000) <input type="checkbox"/> Cancel
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)	<input type="checkbox"/> Yes <input type="checkbox"/> Decline NOTE: Beneficiary is the Employee <input type="checkbox"/> Cancel <input type="checkbox"/> Cancel
6. LONG TERM DISABILITY (LTD) (Compulsory for eligible groups)	<input type="checkbox"/> Enrol <input type="checkbox"/> Not Eligible <input type="checkbox"/> Missed Enrolment (up to 12 months retro premium required) <input type="checkbox"/> Late Application -- Complete Statement of Health for LTD
7. HEALTH (Optional)	<input type="checkbox"/> Yes <input type="checkbox"/> Decline <input type="checkbox"/> Change If Yes or Change complete section C on page 3 <input type="checkbox"/> Cancel
8. DENTAL (Optional)	<input type="checkbox"/> Yes <input type="checkbox"/> Decline <input type="checkbox"/> Change If Yes or Change complete section C on page 3 <input type="checkbox"/> Cancel 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 [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 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:** _____

**** 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 ****
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 BENEFIT PROGRAMS
ACTIVE EMPLOYEE ENROLMENT/CHANGE FORM**



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

REQUESTING:

<input type="checkbox"/> Enrolment	<input type="checkbox"/> Change Coverage	<input type="checkbox"/> Change Dependents	<input type="checkbox"/> Late Application – Attach completed Statement of Health
<input type="checkbox"/> Life Changing Event – Attach required documentation (refer to the table on page 1)	<input type="checkbox"/> Change Name	<input type="checkbox"/> Change Address/ Telephone	<input type="checkbox"/> Combining two employee plans ²
<input type="checkbox"/> Transfer Coverage (Active Employee) ¹	<input type="checkbox"/> Terminate/Cancel Coverage	<input type="checkbox"/> Other _____	

Medavie Blue Cross Identification # (11 digits)	Enrol/Add	Change	Employee Only	Employee +1 dependent	Employee +2 or more dependents
¹ For transfer:	HEALTH <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
² For combining – ID # of spouse:	DENTAL <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

EMPLOYEE INFORMATION

Last Name of Employee	First Name	Middle Initial(s)	Date of Birth (DD-MM-YY)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Telephone Number () -
Language Preference <input type="checkbox"/> English <input type="checkbox"/> French	Address (Street & No.)	City or Town	Province	Postal Code	Email

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 <input type="checkbox"/> Special Dependent <input type="checkbox"/>
<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 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):
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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 characters)
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.

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**