

**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**. Proof of Medicare coverage must also be submitted (i.e. Medicare card).
- 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** submit your changes within 31 days of experiencing a 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 each of the following life changing events, documentation is required, as it becomes available.

Life Changing Event	Who can be added?	Documentation Required
Marriage	Employee, Spouse, and Dependent Children	Marriage Certificate
Common-Law	Employee, Spouse, and Dependent Children	<a href="#">Statutory Declaration of Common-Law Partner form</a>
Birth or Adoption	Employee, Spouse, and Dependent Children	Birth Certificate or legal adoption papers
Divorce/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 student's first year of enrolment only. Proof of full-time enrolment in an accredited post-secondary educational institution.
Involuntary Loss of Employee's Coverage	Employee, Spouse & 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 dependents do not enroll in or make changes **within 31 days** of becoming eligible to participate or experience a life changing event, you and/or your 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:**

- Eligibility Criteria Benefit Fact Sheet: describes the eligibility criteria to participate in the employee benefit plans;
- Late Applicant Benefit Fact Sheet: describes the Late Applicant provisions and the associated risks;
- Leave of Absence – Continuation of Coverage Benefit Fact Sheet: describes the maximum periods for continuing benefit coverage while on an approved leave without pay or lay-off; 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**



**SECTION A TO BE COMPLETED BY EMPLOYEE**

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

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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**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                       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 DESIGNATIONS AND CHANGES**

**8. 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**

**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 \*\***  
 P.O. Box 6000, Fredericton, NB E3B 5H1  
 Tel: 1-800-561-4012; Fax: (506) 457-7388; Email: [info@vestcor.org](mailto:info@vestcor.org)

Continued on next page

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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	Employee Only	Employee +1 dependent	Employee +2 or more dependents
(11 digits):	HEALTH & TRAVEL <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	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 ( ) -
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Language Preference <input type="checkbox"/> English <input type="checkbox"/> French	Address (Street & No.)	City or Town	Province	Postal Code
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**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**

<b>If Full-Time Student:</b>	Name of accredited school, college or university	School Term (DD-MM-YY) From: To:
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<b>If Special Dependent:</b>	Coverage is subject to approval by Medavie Blue Cross (MBC). The <a href="#">Special Dependent Questionnaire</a> located at <a href="https://www.medaviebc.ca/en/resources">https://www.medaviebc.ca/en/resources</a> must be completed and emailed, mailed or faxed to MBC.
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**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](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.

<b>Signature of Employer:</b> _____	<b>Date (DD-MM-YY):</b> _____
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**\*\* 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](mailto:MAAX.Policy.Administrators@medavie.bluecross.ca)