SASKATCHEWAN School Boards ASSOCIATION

EMPLOYEE BENEFIT PLAN ENROLLMENT FORM

School Division Name: **Prairie Spirit 206** Group # : **206-3**

Manulife Division # : **105** Plan: **GD**

EMPLOYEE NAME (Last) _____ (First) _____ (Initial) ____

ADDRESS _____ **CITY** _____ **PROV** _____ **POST. CODE** _____

BIRTHDATE	HIRE DATE	EFFECTIVE DATE
___/___/___	___/___/___	___/___/___
dd / mm / yy	dd / mm / yy	dd / mm / yyy

Please indicate:
- ❑ New Enrollment
- ❑ Information Change

Were you covered under the Saskatchewan School Boards Association Benefit Plan in the last 12 months Yes____ No ____

OCCUPATION _____ SEX: *Male / Female* SMOKER: *YES / NO*

ANNUAL EARNINGS $_____ DEPT / PAY TYPE _____ **(max 2 digits)** **LANGUAGE:** ***ENGLISH / FRENCH / OTHER***

MARITAL STATUS *SINGLE / MARRIED / COMMONLAW / SEPARATED / DIVORCED / WIDOWED*

FAMILY INFORMATION

This information is necessary if you carry dependent life, health, vision or dental coverage with this plan.

NAME (First, Initial, Last)	RELATIONSHIP Spouse / Dependent Child / Dep. & Physically or Mentally Challenged	DATE OF BIRTH (dd / mm / yy)	SEX (M / F)	EDUCATIONAL INSTITUTE (for dependent students age 21 to 25 years)
_____	Spouse	___/___/___	____	_____
_____	Child	___/___/___	____	_____
_____	_____	___/___/___	____	_____
_____	_____	___/___/___	____	_____
_____	_____	___/___/___	____	_____

BENEFICIARY INFORMATION

BENEFICIARY DESIGNATION (First, Initial, Last) This is a revocable appointment **RELATIONSHIP** **Percentage**

_____ _____ _____ %

_____ _____ _____ %

If you carry optional life insurance through this plan, the beneficiary will be the same as above unless otherwise specified. This will revoke all previous beneficiary appointments. If there is not enough room to name your beneficiaries, please complete **Beneficiary Change Form**.

TRUSTEE /GUARDIAN (If Beneficiary is under 18 years of age, please complete the TRUSTEE / GUARDIAN information below)

_____ _____

COVERAGE INFORMATION

	PLAN TYPE	
CORE BENEFITS	A, B, C, D, E or N/A	
Life & Accidental Death & Dis.	**B**	Employee
Long Term Disability	**C**	Employee
Employee Family Assistance		

*S*ingle, Couple or Family must be based on actual family unit.

Coordination of Benefits - If you or your dependents are covered for similar health & dental benefits under another group plan please indicate **the coordinating Insurance Company Name/Plan #** on the applicable line corresponding to the associated benefit(s) listed below.

GROUP BENEFITS		**Please indicate family unit**
Extended Health	**B**	Single / Couple / Family / _____
Vision	**B**	Single / Couple / Family / _____
Dental Care	**C**	Single / Couple / Family / _____

INDIVIDUAL BENEFITS: To purchase Optional Life, Optional Accidental Death & Dismemberment or Critical Illness, please see your plan administrator for forms

Privacy Statement: The Insurers and Saskatchewan School Boards Association are committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business .I hereby apply for insurance under the group policy issued to the Saskatchewan School Boards Association on behalf of the employing school division, subject to all the terms, conditions and provisions of said policy. I authorize the deduction from my pay of the required contribution, if any, toward the cost of the insurance. I have made my beneficiary designation and I reserve the right to change this designation at a later date.

SIGNATURE OF EMPLOYEE _____ **DATE** _____

This certificate is valid only while the employee continues in good standing in accordance with the plan. Details of the benefits provided are set forth in the group insurance policy issued to the Saskatchewan School Boards Association, who will furnish information and claim advice upon receipt.

Original – Sask School Boards Association 1 copy - Employee 1 copy - School Division