City of Surrey
Benefits Plan Form

Fire

☐ **INITIAL APPLICATION**
☐ **CHANGE**

EMPLOYEE INFORMATION					
Last Name		First Name			Middle Initial
Employee Number		**Marital Status**			**Gender**
Social Insurance Number		☐ Married	☐ Common Law	☐ Single	M ☐ F ☐
Date of Birth (dd/mm/yyyy)	Date of Hire (dd/mm/yyyy)	**Phone Number**		Address	

DEPENDENT INFORMATION (Children under 21 years of age or 21 and over Student in full-time attendance at a post secondary institution.)			
Dependents Names (Last Name, First Name, Initials) ADD ☐ DELETE ☐	Gender (M/F)	Date of Birth (dd/mm/yyyy)	Student/Disabled - (Information required)
Spouse			**N/A**
Child			**S D**
Child			**S D**
Child			**S D**
Child			**S D**
Child			**S D**
Child			**S D**

PHARMACARE REGISTRATION NUMBER_____
(Pharmacare Phone Number: 604-683-7151 or 1-800-663-7100)

Please indicate coverage desired.

Provincial Medical (MSP)	Extended Health Care (EHC)	Dental Care
PHN _____	*Single* ☐ *Family* ☐ *No Coordination of Benefits* ☐ Spouse's Carrier _____ Spouse's Group No. _____	*Single* ☐ *Couple* ☐ *Family* ☐ *No Coordination of Benefits* ☐ Spouse's Carrier _____ Spouse's Group No. _____

I understand that for our Manulife coverage of Extended Health and Dental if I do not enroll my spouse/dependents when first able, any future application is limited to life changes. Examples: divorce of my spouse, new spouse, death of my spouse or a change to my spouse/dependents benefit coverage.

_____ _____
Employee Signature Employee Signature

ELECTIVE (OPTIONAL) BENEFITS

The following benefits are optional and paid by you through payroll deduction.

OPTIONAL ACCIDENTAL DEATH & DISMEMBERMENT		
Initial coverage and changes in this coverage are effective with your benefits start date following receipt of this signed form.		
Benefit Coverage and Beneficiary Designation ***Note:*** *You will be the beneficiary of your insured spouse and dependent child(ren)'s insurance.*	**Type of Plan:** Plan 1 – Employee Only, or ☐ Plan 2 – Employee and Family ☐	**Amount of Coverage** (units of $10,000 to a maximum of $300,000) $ _____
End Optional AD&D Coverage ☐	Signature_____ Date_____	

OPTIONAL LIFE INSURANCE (You must obtain an additional insurance application from Human Resources for this benefit)			
A separate application must be completed for Optional Life. Initial coverage and increases in coverage are effective when the application is approved by the Insurance Company. Decreases or Cancellations in coverage are effective the first of the month following receipt of this signed form.			
Employee Coverage and Beneficiary Designation	Amount (units of $10,000 to a maximum of $500,000) $ _____ Smoker? Yes ☐ No ☐		
For Office Use Only*:** ***Approved: *[Date]* *Employee* _____ *Spouse* _____ ***Declined:*** *Employee* _____ *Spouse* _____			
Spouse Coverage ***Note:*** *You will be the beneficiary of your spouse's insurance if you are living. Otherwise the beneficiary will be your estate.*	Amount (units of $10,000 to a maximum of $300,000) $ _____ Smoker? Yes ☐ No ☐		
End Optional Insurance Coverage Employee ☐ Spouse ☐	_____ _____ Employee Signature Date		

I hereby declare that the information on this application, to the best of my knowledge and belief, is complete and true and authorize my employer to make the necessary payroll deductions, if any, for my contributions. I understand the use of my Social Insurance Number is for identification purposes and hereby authorize its use for this purpose.

_____ _____

Employee Signature Date Signed

City of Surrey

DECLARATION FOR QUALIFICATION OF PARTNER

I, _____, hereby elect _____
to qualify as my Common-Law Spouse.

Date of cohabitation _____.

The term "Common-Law Spouse" means a person who resides with the employee in a common-law relationship for a period of at least one year. **Documentation for proof of residency is required and must be submitted along with this declaration**.

I warrant that the reasons given above to substantiate the qualification of my Spouse are accurate and I understand that the strict accuracy of this information is a condition of the exercise of this right of qualification by me. I further understand that no payment will be made under a benefit provision in respect of the above person, if, on the date of a claim, he or she could not at that time be qualified as a Spouse.

Effective benefit entitlement will be subject to receipt of this signed form together with supporting documentation.

Dated at _____ this _____ day of _____ in the year _____.

_____
(Signature of Insured)

_____
(Printed Name of Insured)