

BCIT APPLICATION AND CHANGE FORM for MANULIFE FINANCIAL EXTENDED HEALTH AND DENTAL BENEFITS

PLEASE PRINT (Sections A & B for all, Section C only for Change of Status information only)

SECTION A. To be completed by Human Resources

Plan Contract No. 0083238	Organization B.C.I.T.	Member Certificate No. <small>(Last 6 digits of employee #)</small>	
Employee's Location No.	Employee's Class No.	Employee Plan No.	Eligibility Date:

SECTION B. To be completed by Employee

Employee Name (First/Initial/Last)		
Date of Birth (dd/mm/yy)	Gender Male <input type="checkbox"/> Female <input type="checkbox"/>	Type of Coverage Required Employee only <input type="checkbox"/> Employee & Family <input type="checkbox"/>

Dependent Information

Spouse's Name (first/initial/last)		Gender (m/f)	Date of Birth (dd/mm/yy)	Coordination of Benefits ***
Spouse	02			
Dependent Children		Gender (m/f)	Date of Birth (dd/mm/yy)	Student Univ/College (Place & Enrolment dates)
	03			
	04			
	05			
	06			

(if necessary, please use the back of sheet for additional dependents)

SECTION C. To be completed by Employee

CHANGE OF INFORMATION SECTION:

<i>Complete this section plus applicable parts of Sections A & B</i>		ADDITION <input type="checkbox"/>	DELETION <input type="checkbox"/>
Change Status:	Marriage <input type="checkbox"/>	Common-Law* <input type="checkbox"/>	Date relationship began (dd/mm/yy) _____
	Birth* * <input type="checkbox"/>	Adoption* * <input type="checkbox"/>	Custody** <input type="checkbox"/>
	Divorce/Separation <input type="checkbox"/>	Other ** <input type="checkbox"/>	Effective date _____

*Declaration for Designation of a Common-Law Partner form must also be completed / ** Applicable papers must be copied and attached to application

FAIR PHARMACARE

Are you enrolled with PHARMACARE? Yes <input type="checkbox"/> No <input type="checkbox"/>

*****COORDINATION OF BENEFITS (COB)**

"S" if your spouse has single coverage under his/her employer's plan "F" if your spouse has family coverage under his/her employer's plan "N/A" if your spouse has no coverage "W" if your spouse has waived coverage under his/her plan

I hereby request that I be insured for the benefits for which I am or may become eligible under the terms of the above group policy issued by THE MANULIFE FINANCIAL COMPANY (previously MARITIME LIFE). I authorize that my BCIT Employee Number may be used as my personal identification number for claims information and plan contributions for me and my dependants.

Signature of Employee

Date

NEW EMPLOYEES: PLEASE NOTE THIS FORM MUST BE RETURNED IN ORDER FOR YOUR BENEFITS TO BE IMPLEMENTED
CHANGES: WILL BE EFFECTIVE ON THE FIRST OF THE MONTH FOLLOWING RECEIPT OF THIS FORM IN HUMAN RESOURCES