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.	Organization		Member Certificate No.
0083238	**B.C.I.T.**		(Last 6 digits of employee#)
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)	Sex ☐ Female ☐ Male ☐ Non-Binary	Type of Coverage Required Employee only ☐ Employee & Family ☐

Dependent Information

		Spouse's Name (first/initial/last)	Gender (m/f)	Date of Birth (dd/mm/vv)	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:**

Complete this section plus applicable parts of Sections A & B ADDITION ☐ DELETION ☐

Change Status: Marriage ☐ Common-Law* ☐ Date relationship began (dd/mm/yy)_____

Birth* • ☐ Adoption** ☐ Custody** ☐ Effective date _____

Divorce/Separation ☐ Other ** ☐ _____

**Declaration of Common Law* form must also be completed

** *Applicable papers must* be copied and attached to application

FAIR PHARMACARE

Are you enrolled with PHARMACARE?

Yes ☐ No ☐

*****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 infonnation 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

☐ I confirm that I and each of my dependents (if applicable) are covered by a Provincial Health Care plan (ie Medical Services Plan of BC or equivalent), and I acknowledge that should this change, I am obliged to report the change to my employer.

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