Vancouver Coastal Health

NEW HIRE INFORMATION

Site: _____ **Employee ID #:** _____

Position: _____ **Department:** _____

Full Legal Name:		
Mailing Address:		
City/Province/Postal Code		
Phone Number:	**Cell:**	
Email Address:		
Date of Birth:	**Year:** **Month:**	**Day:**
Social Insurance Number:		

Emergency Contact Information:

This is confidential information that is only to be used in the event of an emergency.

Name:		**Relationship:**	
Phone Number:	**Cell:**		

Regulatory Licensure/Registration: * Please attach copy of licensing/registration *

BCCNM License Type (RN/RPN/LPN/NP):		
	Registration #:	expiry date:
Other:	Registration #:	expiry date:

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT

Employee's Signature: Date:

Municipal Pension Plan Employee Declaration

LAST NAME, FIRST NAME			
HEALTH AUTHORITY	PHC ☐	PHSA ☐	VCH ☐
EMPLOYEE ID			

It is the employee's responsibility to inform the employer of their eligibility to enroll in the Municipal Pension Plan. To do so please answer the following questions:

1. Are you currently an active member of the Municipal Pension Plan?

   ☐ Yes ☐ No

2. Have you been contributing in the last 30 days?

   ☐ Yes ☐ No

   ***If** uncertain contact the Municipal Pension Plan at 1-800-668-6335

3. Are you currently receiving a pension from the Plan?

   ☐ Yes ☐ No

I understand that it is my responsibility to inform my employer of my eligibility to enroll in the Plan (if employed with more than one Plan employer).

The Municipal Pension Guide Booklet may be found on the Pension website www.pensionsbc.ca.

***Please provide proof of Pension enrolment if currently contributing to the Plan**

_____ _____

Employee Signature **Date**

_____ _____

Verified by (office use only) **Date**

Municipal Pension Plan

WAIVER OF PENSION COVERAGE
(Part-Time Employees only)

PENSION PLAN USE ONLY
PERSON ID

Municipal Pension Plan
PO Box 9460
Victoria BC V8W 9V8

Location 2995 Jutland Road, Victoria

Web mpp.pensionsbc.ca

Victoria 250 953-3000
Toll-free in Canada/U.S. 1 800 668-6335
Fax 250 953-0421
E-mail MPP@pensionsbc.ca

INSTRUCTIONS

- This form is to be completed by an employee who is eligible to participate in the Municipal Pension Plan (the "Plan") but who elects NOT to. (See Page 2 for employee eligibility).
- The employee and the employer should each retain a copy of this form for their records.
- If the employee subsequently elects participation under the Plan, the employer must forward a copy of this form to the Plan to verify that the employee waived optional enrolment at the time the employee was first eligible to enrol.

EMPLOYER NAME	EMPLOYER NO.

EMPLOYEE NAME	EMPLOYEE SOCIAL INSURANCE NO.

Employee Declaration:

1. I declare that I am not currently making contributions to the Plan and I have not made contributions to the Plan within one month prior to my hire date with my new employer.
2. I understand that I am eligible to participate in the Plan and that if I wish not to be enrolled in the Plan this form must be signed and returned to my employer within 30 days of my initial eligibility date.
3. I have been provided with an explanation or summary of the Plan, and of the relevant entitlements and obligations under the Plan.
4. I do not wish to participate in the Plan at this time.
5. Unless I subsequently elect to enrol in the Plan, I understand that I will NOT be notified of future amendments or improvements to the Plan.
6. I understand that, under the current plan rules, I may subsequently elect to enrol in the Plan by providing my employer with a completed and signed *Pension Enrolment Election.* It is my responsibility to provide such notice. However, there is no guarantee that the Plan rules will not change, and I understand that my ability to enrol may not necessarily exist at a later date.
7. Further, I understand that if I subsequently provide written notification of my election to enrol, such an election will be prospective only. Enrolment will not be retroactive.
8. I understand that if I subsequently become enrolled in the Plan, I will not be able to purchase any service prior to the date of actual enrolment.
9. This waiver will cease to have effect if a change in my employment status or the Plan rules requires that I participate in the Plan.

By signing below, I expressly waive my rights to participate in the Plan and to receive any pension benefits.

EMPLOYEE SIGNATURE	DATE SIGNED YYYY / MM / DD

Freedom of Information and Protection of Privacy Act–The personal information on this form is collected under the authority of the *Public Sector Pension Plans Act* and will be used by the Pension Corporation to administer a plan member's pension and other non-pension benefits. If you have any questions about the collection and use of this information, contact the Chief Executive Officer at 2995 Jutland Road, Victoria BC V8T 5J9 or by telephone at 250 387-1002.

RETURN ORIGINAL TO THE PLAN
ONLY IF WAIVER IS SUBSEQUENTLY REVOKED

EMPLOYER AND EMPLOYEE
MAKE A COPY FOR YOUR RECORDS

Clear Form

Claims processed by
PACIFIC BLUE CROSS®

for PBC office use only

Application for Group Benefits Program

Healthcare Benefit Trust
Joint Community Benefits Trust
Joint Facilities Benefits Trust
Joint Health Science Benefits Trust

Mailing Address:
PO Box 7000, Vancouver, BC V6B 4E1
Street Address:
4250 Canada Way, Burnaby, BC
Fax: 604 419-2149

❑ New applicant
❑ Reinstatement

Employer/Plan Administrator – complete this section	
Policy 50000	**Effective date** (mm/dd/yyyy)
☐ Dental	
☐ EHC	
Benefits ID #	

Applicant – Complete this section

First name	Last name	Middle initial	Sex ☐ M ☐ F	Birthdate (mm/dd/yyyy)

Address	City	Province	Postal code

	First name	Last name	Middle initial	Birthdate (mm/dd/yyyy)	Sex	Relationship to you
Spouse					Sex ☐ M ☐ F	☐ Married ☐ Common-law
1st child					Sex ☐ M ☐ F	
2nd child					Sex ☐ M ☐ F	
3rd child					Sex ☐ M ☐ F	
4th child					Sex ☐ M ☐ F	

If child is over plan's age limit (e.g., 19 or 21) and attending school full-time, attach the Application for Over-Age Dependent Child. If child is disabled, state details of disability to apply for coverage beyond plan's age limits. Attach completed Disabled Dependent Application.

Were you or your dependents covered within the last 6 months, or are you presently covered, under another group Dental or EHC plan? ☐ Yes ☐ No If yes, provide:

Insurance company	Name of cardholder of other plan	Group/policy number	Effective date	ID number

Employment type: ☐ Regular full time ☐ Regular part time ☐ Retiree

Benefits covered under other plan: ☐ EHC ☐ Dental Is the plan still active? ☐ Yes ☐ No If no, state termination date: (mm/dd/yyyy)

I agree to the conditions of the contract between Pacific Blue Cross (PBC) and one of the health and welfare trusts listed above (referred to in this authorization as the "Trust"). *If you require confirmation of which trust applies to you, contact your union or your employer.* If the contributions or a portion are employee-paid, I authorize my employer to deduct the required contributions from my earnings. I understand that the Trust uses my Social Insurance Number to create a Benefits Identification Number that is unique to me and that is used to identify me and to administer the benefit plan. I confirm that the information I have provided is true and complete. If I should receive a settlement or a judgment against a liable third party for benefits covered under my group plan, I agree to, and authorize the party to, reimburse PBC up to the amount advanced to me pending such settlement or judgment.

I understand and consent that some of the personal information provided by me and my dependents under this group plan ("Personal Information") may be disclosed to agents and representatives of PBC as claims paying agent under this group plan, and to other providers/insurers and their agents and representatives for the purposes of assessing and providing benefit coverage. I also understand and consent that the Personal Information may be disclosed to the Trust and agents of that Trust (which agents may include the Healthcare Benefit Trust). I understand that PBC will not disclose the Personal Information to my employer except to the extent that such disclosure is required for the purposes of having my employer complete this form, and except when required or permitted by law. I understand that PBC shall collect, use and disclose this Personal Information in accordance with its privacy policy. *A copy of the privacy policy is available by contacting PBC and is also available at www.pac.bluecross.ca.*

☐ I have read the above terms and conditions. ☐ I hereby declare that all the information provided in this application is true and complete.

Signature of applicant	Date (mm/dd/yyyy)	Email address

Employer / Plan Administrator – Complete this section

Name of organization	Division	Sub-division	Class code

Applicant's occupation	Employment type: ☐ Regular full time ☐ Regular part time ☐ Casual

Date of employment (mm/dd/yyyy)	Date of eligibility (mm/dd/yyyy)	Date of rehire/return from leave (mm/dd/yyyy)	Hours worked per week

If we have questions about this application, how can we contact you? ☐ Phone ☐ Email Phone (ten digits) Email address

☐ I have read the above terms and conditions. ☐ I hereby declare that all the information provided in this application is true and complete.

Signature of employer	Date (mm/dd/yyyy)

CARESnet® provides Pacific Blue Cross members with secure online access to their personal health and dental benefit information. When you receive your ID card, visit www.pac.bluecross.ca to register for CARESnet®

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