THE UNIVERSITY OF BRITISH COLUMBIA

EXTENDED HEALTH CARE & DENTAL BENEFITS ENROLLMENT FORM

Section A – Member Details

Member Name: _____ _____
first name last name

Birth Date: _____ _____ _____
yyyy mm dd

Fac/Staff:
☐ Faculty
☐ Staff

Section B – Benefit Plan Election and Coverage Type

Please indicate coverage type by selecting the appropriate box.

Extended Health Care:

☐ Single
☐ Couple (you plus 1 dependent)
☐ Family
☐ No Coverage

Dental:

☐ Single
☐ Couple (you plus 1 dependent)
☐ Family
☐ No Coverage

Section C – Dependent Details

Please complete the following section if you are enrolling dependents under your Plan. Eligible dependents include:

- your spouse, common-law spouse, same-sex partner
- dependent children who are single and entirely dependent on you for financial support and age 18 and under, or, between age 19 and age 24 and under, if a full-time student attending an educational institution recognized by Canada Revenue Agency (for Quebec Members please check with your plan administrator for dependent student age maximum)
- disabled children of any age

Please note: Canadian Life and Health regulations (CLHIA) state:

1. A spouse must first claim from his/her own employer's plan.
2. Covered children must first claim from the plan covering the parent with the earlier date of birth in the year. If both parents were born in the same month, the earlier day is used.

Dependent Names		**DOB**			**Gender**	**Student**	**Disabled**
first	last	yyyy	mm	dd	m / f	yes / no	yes / no

THE UNIVERSITY OF BRITISH COLUMBIA

EXTENDED HEALTH CARE & DENTAL BENEFITS ENROLLMENT FORM

Section D - Extended Health Care & Dental Benefits Authorization

I agree to the conditions of the contract between my employer and Sun Life and understand that I and my dependents (if any) must be continuously enrolled under the Provincial Health Plan in order to participate in the extended health care plan.

You must be authorized to disclose information about your spouse and dependents in order to enroll them in the plan. By enrolling in this plan, you authorize the following:

- Sun Life Assurance Company of Canada, its agents and service providers to use and exchange information collected in this form to underwrite, administer benefits and pay claims,
- The University of British Columbia to use the information collected in this form for benefits administration and to make any necessary payroll deductions.

You agree all information in this form is true and complete. A photocopy or an electronic version of this authorization is as valid as the original.

Personal information provided on this form is collected pursuant to section 26 of the *Freedom of Information and Protection of Privacy Act,* RSBC 1996, c. 165 (FIPPA) for the purposes of benefits administration, claims submission and to make any necessary payroll deductions. The information will be used, retained & disclosed by UBC in accordance with FIPPA. For further information, please email benefitsinfo@hr.ubc.ca.

Employee Signature: _____ **Date:** _____ (yyyy) _____ (mm) _____ (dd)

For Office Use Only:

GROUP NUMBER: 25205	**Division:**	**Class/Plan:**
☐ New Member	(= 7 digit UBC Emloyee ID No.)	
☐ Re-hire	**Member ID No:**	

Date of Hire/Re-Hire: _____ (yyyy) _____ (mm) _____ (dd)

Effective Date of Coverage: _____ (yyyy) _____ (mm) _____ (dd)