THE UNIVERSITY OF BRITISH COLUMBIA

INCOME REPLACEMENT PLAN - STAFF ENROLLMENT FORM

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 purpose 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.

Name of Employee (first name, last name)	Employee Identification Number or SIN	Department

Eligible employees have two options for when their Income Replacement Plan (Long-Term Disability) coverage begins. Please read each option carefully and indicate the option you prefer by selecting the appropriate box and signing. Those who are eligible and select Option 2 will be required to complete additional information.

Option 1: Coverage under the Income Replacement Plan becomes effective *after one year of continuous employment* at the University. Coverage at this time is mandatory; you will automatically be enrolled under the Plan after one year of continuous employment and premiums will be deducted from your pay as necessary. During your first year, you are ineligible to receive benefits under the Income Replacement Plan.

☐ I hereby apply for the Income Replacement Plan to be effective after one year of continuous employment with the University.

Signature of Employee **Date**

FOR OFFICE USE ONLY (OPTION 1)	
Effective Date	Employee ID

OR

Option 2: Coverage under the Income Replacement Plan becomes effective *on your date of hire* with the University and premiums will be deducted from your pay as necessary. You are eligible for Option 2 only if you had long-term disability coverage for at least one year with your previous employer and coverage terminated within 61 days of your date of hire with UBC.

☐ I hereby apply for the Income Replacement Plan to be effective on my date of hire. I hereby certify that I had long-term disability coverage for at least one year with my previous employer _____, and my coverage end-date was _____, which is within 61 days of my date of hire with UBC.

Signature of Employee **Date**

HUMAN RESOURCES APPROVAL (OPTION 2)	
One year waiting period for UBC Income Replacement Plan waived.	
SIGNATURE	DATE SIGNED