



Retirement & Survivor Benefits (RSB) Program Application Form (2017)

Section A – Member Information:

Staff

Faculty

| | | | | | |
|---------------------------|--|--|--|----------------|---------------------------|
| Name: | | | first name | middle initial | last name |
| Home Address: | | | number | street | city province postal code |
| Home Telephone: | | | E-mail Address: | | |
| Cell phone: (optional) | | | Personal Health Number (PHN): (if applying for MSP) | | |
| Social Insurance Number: | | | UBC Employee ID: | | |
| Date of Birth: | | | month | day | year |
| | | | Retirement Date: | | |
| | | | month | day | year |

Section B – Dependent Information

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, supported by you and up to age 19 or up to age 25 if in full time attendance at a school or University. For the benefits programs listed here, with the exception of Medical Services Plan (MSP), eligible dependents include disabled children of any age.

| First name, Last name and Personal Health Number (PHN) from MSP CareCard if signing up for MSP through UBC | Relationship of Dependent to You | Gender M/F | Date of Birth month/day/year | If student: indicate school name and study end date (include location if outside of Canada) | Indicate if Disabled Yes/No |
|--|----------------------------------|------------|------------------------------|---|-----------------------------|
| Name: ----- PHN: | | | | | |
| Name: ----- PHN: | | | | | |
| Name: ----- PHN: | | | | | |

Section C – Benefit Plan Election

Please make your benefit plan elections by ticking off the appropriate box(es). Leave blank the benefit(s) you are not enrolling for.

- Select any or all of the three UBC benefit plans (EHB, DEN, or EFAP). Rates are current and subject to change
- If you choose to enroll in Extended Health, you must ensure that you have Medical Services Plan coverage (MSP) through either UBC or elsewhere. To enroll in MSP through UBC, select Benefits Option 4.
- Your total monthly premium will be the sum of your individual benefit elections (from 1 – 4) below.

1) Extended Health Benefit

Lifetime maximum of \$200,000 per person. \$1,000 annual deductible per single or family (January – December). Members residing in Ontario or Quebec are subject to provincial Retail Sales Tax on Extended Health premiums (8% ON, 9% QC). Members residing in Saskatchewan are subject to Provincial Sales Tax on Extended Health premiums (6% SK).

| Coverage | Monthly Premium | |
|----------|-----------------|--------------------------|
| Single | \$ 63.75 | <input type="checkbox"/> |
| Couple | \$127.53 | <input type="checkbox"/> |
| Family | \$127.53 | <input type="checkbox"/> |

2) Dental Plan – Direct Pay

Dental claims can be submitted electronically to Sun Life. Payments can be made to your dentist or yourself. **Members residing in Ontario or Quebec are subject to provincial Retail Sales Tax on Dental premiums (8% ON, 9% QC). Members residing in Saskatchewan are subject to Provincial Sales Tax on Dental premiums (6% SK).**

| Coverage | Monthly Premium | |
|----------|-----------------|--------------------------|
| Single | \$ 45.81 | <input type="checkbox"/> |
| Couple | \$ 91.91 | <input type="checkbox"/> |
| Family | \$136.26 | <input type="checkbox"/> |

3) Employee & Family Assistance Program (EFAP)

Provides confidential counseling services to individuals and their family members by our service provider, Shepell™. Coverage is also extended to your dependents at one flat premium per month.

| Coverage | Monthly Premium | |
|----------------------|-----------------|--------------------------|
| Single/Couple/Family | \$ 4.00 | <input type="checkbox"/> |

4) Medical Services Plan (MSP)

Complete this section **only** if you want to enroll *in MSP through UBC*. If you prefer to enroll directly with MSP, or if you are already covered, please skip this section. To enroll with MSP directly or to get more information, please contact: Vancouver and Lower Mainland – 604.683.7151 and Toll Free – 1.800.663.7100.

| Coverage | Monthly Premium | |
|------------|-----------------|--------------------------|
| One Adult | \$ 75.00 | <input type="checkbox"/> |
| Two Adults | \$150.00 | <input type="checkbox"/> |

Section D – Method of Payment

Pre-authorized payment (direct debiting) is the **only** method of payment available. Please attach a blank cheque marked “VOID” to the bottom of this application form. Your bank account will be debited for the amount of your total monthly premium on the first business day of the month.

| |
|------------------------------------|
| Your total monthly premium: |
| \$ _____ |
| <i>(Sum of 1 - 4)</i> |

→ ATTACH VOID CHEQUE HERE ←

Section E – Member Authorization

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

- o *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.
- o *The University of British Columbia* (the “Payee”) to use the account information collected from the void cheque attached in this form for Pre-Authorized Debit (PAD) agreement to draw on your account indicated above with the Financial Institution, for monthly health benefits payments to be debited on the 1st business day of the month.

I certify that all information contained in this form is accurate and complete. I agree to inform the Payee, in writing, of any change in the information provided prior to the next due date of the PAD. I warrant and guarantee that the signature required to sign on this account has signed this agreement. I acknowledge my Financial Institution is not required to verify that any purpose of payment for which a PAD was issued has been fulfilled by the Payee or that a PAD has been issued in accordance the particulars of the Authorization including, but not limited to, the amount, as a condition to honouring a PAD issued by the Payee on our account. This Authorization may be cancelled at any time upon notice by me to the Payee at least 10 days prior to the PAD being issued. I understand and agree to this PAD arrangement and to the disclosure of any confidential information to any third parties as may be required to process the PAD in accordance with the CPA Rules. I understand that monthly benefits premium rates are subject to change. I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD agreement. To obtain more information on recourse rights or rights to cancel a PAD agreement, or a sample cancellation form, please contact your Financial Institution or visit www.cdnpay.ca. A photocopy or an electronic version of this authorization is as valid as the original.

Member Signature: _____ Date: _____
month day year

Please send the form to: Janet McHugh
UBC Human Resources, 600 - 6190 Agronomy Road, Vancouver, BC. V6T 1Z3
Tel : 604.822.4580 | Fax : 604.822.8134
E-mail : janet.mchugh@ubc.ca | Web : www.hr.ubc.ca/benefits/retirement-and-survivor-benefits/