

# Enrolment/Change Form

## Employee Information

Employee's Last Name

Given Names in Full

Ministry

M  F

Date of Birth (year/month/day)

Gender

Employee ID

**Enrol** (on commencement)

Make your choices on this form and return it to your Ministry Pay and Benefits Office within 31 days of commencement.

**Change** (after commencement)

Make your changes on this form and return it to your Ministry Pay and Benefits Office within 31 days of a life event or when making a change for any other reason. Mark only those benefits you wish to change.

Effective Date of Change: \_\_\_\_\_

Life Event (refer to Definitions section)

Other

Reason for the Change (e.g. marriage): \_\_\_\_\_

This form does not include an area for the Long Term Disability. Long Term Disability is a mandatory benefit and coverage commences automatically when eligibility requirements have been met.

## Group Life Insurance

### Core Life Insurance (check one box only)

Core coverage is mandatory. You must maintain a minimum level of at least 1 x annual salary. Evidence of insurability is not required on commencement. If you are between age 65 – 69, your Core Life Insurance coverage is 1 times salary, as 2.5 times salary is not an option. If you are interested in applying for the Enhanced level and are under age 65, you must select a minimum of Core 2.5 x annual salary. If you are between the age of 70 – 75, Core Life Insurance coverage is a lump sum of \$25,000.

1 x salary  2.5 x salary

### Dependent Life Insurance (check one box only)

Opt Out  Enrol

### Enhanced Life Insurance (check one box only)

**How to enrol in Enhanced Life Insurance on commencement:** If you wish to enrol in Enhanced Life Insurance you must be under age 70 and, you must complete and submit an *Evidence of Insurability* form to The Great-West Life Assurance Company. This form is located in the Forms section of the benefits handbook. Once your application has been adjudicated, you will be informed if your insurance has been approved or denied. Your Enhanced coverage will come into effect on the date that it is approved by Great-West Life. If you are applying for the non-smoker rate, an *Application and Declaration for Non-Smoker Rate* form must be completed and forwarded to **your Ministry Pay and Benefits Office**.

Opt Out

#### Smoker

1 x salary  2 x salary

3 x salary  4 x salary

#### Non-Smoker

1 x salary  2 x salary

3 x salary  4 x salary

**How to change your existing Core or Enhanced Life Insurance after commencement:** In the event you are increasing the level of Core and/or Enhanced life insurance from the amount you currently carry, you must either provide proof of a life event or complete the Evidence of Insurability form, whichever is applicable. This form is located in the Forms section of the benefits handbook. Once your application has been adjudicated, you will be informed if the insurance you requested has been approved or denied. Your Enhanced coverage will come into effect on the first day of the pay period following the date that it is approved by Great-West Life.

**MyCHOICE**

A benefits program for Government of Alberta union employees

Government  
of Alberta

## Dental

(check one box only)

Opt Out   
Core  Single  Family  
Enhanced  Single  Family

## Extended Medical

(check one box only)

Opt Out   
Core  Single  Family  
Enhanced  Single  Family

## Prescription Drugs

(check one box only)

Opt Out   
Core  Single  Family  
Enhanced  Single  Family

## Dependent Information

If you have selected family coverage for any of the benefit plans, you will need to enrol your dependents. Claims will be adjudicated only for those dependents you have enrolled.

If you are adding or unenrolling a dependent, provide the following information for that dependent only. All other dependent information will remain unchanged.

Enrol  Change  Unenrol

### Eligible Benefit Recipient (spouse/benefit partner)

Surname	Given Name	Birth Date (YYYY / MM / DD)	Gender	Relationship (see values)	If not legally married, Cohab Date or Date of AIP* (YYYY / MM / DD)
		/ /	<input type="checkbox"/> M <input type="checkbox"/> F		/ /

### Dependents

Surname	Given Name	Birth Date (YYYY / MM / DD)	Gender	Relationship (see values)	Effective Date of Coverage (YYYY / MM / DD)
		/ /	<input type="checkbox"/> M <input type="checkbox"/> F		/ /
		/ /	<input type="checkbox"/> M <input type="checkbox"/> F		/ /
		/ /	<input type="checkbox"/> M <input type="checkbox"/> F		/ /
		/ /	<input type="checkbox"/> M <input type="checkbox"/> F		/ /

### Relationship Values:

1. Eligible Benefit Recipient (spouse/benefit partner)
2. An Unmarried Dependent or Guardian Child
3. An Unmarried Dependent or Guardian Child over the age of 21 and under 25 who is a full time student at an accredited education institution.
4. An Unmarried Dependent or Guardian Child of any age who is incapable of self sustaining employment because of a disability and is wholly or substantially dependent on you for financial support and maintenance.

\* Adult Interdependent Partner

## Authorization

This information is being collected under the authority of Section 6 of the *Public Service Act* and will be used to provide benefit coverage for an employees' eligible benefit recipient and children. It is protected by the privacy provisions of the *Freedom of Information and Protection of Privacy Act*. If you have any questions about the collection, contact your Ministry Pay and Benefits Office.

I certify that the information given on this form is true, correct and complete to the best of my knowledge. I understand that I may be required to provide proof of evidence of this information. Please sign and return this form to your Ministry Pay and Benefits Office.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

**For Payroll Use — Date of System Entry**

\_\_\_\_\_  
Date