DO NOT WRITE IN THIS SPACE

APPLICATION FOR EXTENDED HEALTH CARE AND VOLUNTARY DENTAL BENEFITS

Mail: Public Service Pension Plan, PO Box 9460, Victoria, BC V8W 9V8
Toll-free Phone: 1-866-876-6777 | Web: pspp.pensionsbc.ca

OFFICE USE ONLY

GSC ID Number	EHC — Effective date of first pension deduction (yyyy-mm-dd)	Dental — Effective date of first pension deduction (yyyy-mm-dd)

PART 1 — APPLICANT INFORMATION

First name	Last name	Middle initial	Birthdate (yyyy-mm-dd)	Gender
				☐ M ☐ F ☐ X

Street address	City	Province	Postal code
Mailing address (if different from above)	**City**	**Province**	**Postal code**
Email address	**Daytime phone number (10 digits)**	**Person ID Number — PID (8 digits)**	

PART 2 — PLAN OPTIONS: For rate information, refer to pspp.pensionsbc.ca

EXTENDED HEALTH CARE options:

☐ **I am applying for Extended Health Care coverage**
- $250 deductible per person/calendar year
- Reimbursement levels: 80% for Tier 1 drugs (BC PharmaCare), 60% for Tier 2 drugs (non-BC PharmaCare), 100% for eligible diabetes supplies, hearing care and vision care (deductible does not apply), 70% for other eligible health benefits
- $250,000 lifetime maximum

☐ **I am declining Extended Health Care** (You must apply for medical coverage under your provincial health insurance plan.)

DENTAL PLAN options:

☐ **I am applying for ESSENTIAL Dental**
- Basic Services
- 75% to a maximum of $750 per person per calendar year

☐ **I am applying for ENHANCED Dental**
- Basic and Major Services
- 75% to a maximum of $1,500 per person per calendar year

☐ **I am declining Dental**

PART 3 — DEPENDANT INFORMATION: Check EHC/Dental box(es) for each dependant if applying for coverage.

FIRST NAME	LAST NAME	MIDDLE INITIAL	BIRTHDATE	GENDER	NAME OF SCHOOL*	DISABLED DEPENDANT*	EHC	DENTAL
Spouse			(yyyy-mm-dd)	☐ M ☐ F		☐	☐	☐
First child			(yyyy-mm-dd)	☐ M ☐ F		☐	☐	☐
Second child			(yyyy-mm-dd)	☐ M ☐ F		☐	☐	☐
Third child			(yyyy-mm-dd)	☐ M ☐ F		☐	☐	☐

*Complete one of these two sections if child is over age 19 and under the age of 25 and attending school full-time, or is disabled.
If you have additional dependants, list them in *Part 5 — Additional Information* on page 2.

PART 4 — OTHER COVERAGE

Complete this section if you previously waived coverage for yourself and/or any of your dependants and are applying after the 60-day enrollment period:

Were you covered within the last 12 months, or are you presently covered, under another group EHC or Dental plan? ☐ Yes ☐ No

Name of insurance company	Group/policy number	ID or certificate number

Benefits covered under the other plan: ☐ EHC ☐ Dental | Is the plan still active? ☐ Yes ☐ No — termination date (yyyy-mm-dd):

PLEASE SIGN FORM ON THE REVERSE SIDE

Note: Terms and conditions for coverage can be found on the reverse side under WHAT YOU NEED TO KNOW

PART 5 — RETURNING TO CANADA MEMBERS

Complete this section if you are applying for coverage after returning from a temporary or permanent absence from outside the country.

On what date did you return to Canada? (mm-dd-yyyy): _____

Provincial medical coverage effective date: _____

PART 6 — ADDITIONAL INFORMATION

_____

_____

WHAT YOU NEED TO KNOW

ELIGIBILITY

- These plans are only available to retired members of the Public Service Pension Plan who are receiving a monthly pension. Each individual covered under the plan must be a permanent resident of Canada who is covered under their provincial medical plan within the province that they reside. To determine if your dependants are eligible for Extended Health Care (EHC) and Dental coverage please refer to your benefits booklet online at: https://onlineservices.greenshield.ca/publicbooklets/pspp.pdf
- **You must apply for coverage within sixty (60) days of your pension approval date.**
- Should you choose not to enroll in the EHC or Dental plan within this 60-day period, you may be eligible to enroll at a later date. However, there are important restrictions and deadlines to meet in order to be eligible to enroll yourself, your spouse and/or dependants after retirement. For more information on these restrictions and deadlines please refer to your benefits booklet online.
- You can enroll in the EHC and/or either the Essential or Enhanced Dental plan and **must participate in the dental plan for a minimum of 12 months before cancelling**.
- If you choose to enroll in the Essential Dental plan, you must participate in the plan for 24 months before upgrading to the Enhanced Dental plan.
- Should you enroll in the Enhanced Dental plan, you cannot downgrade to the Essential Dental plan under any circumstances.

APPLICANT

- If you have a disabled child, provide complete details of the disability such as the nature of the disability, date of onset and prognosis for recovery. His or her coverage will be continued beyond the normal age under your plan if certain criteria are met.
- Some provinces charge tax on voluntary dental insurance premiums.
- Sign and date the application and submit it to Public Service Pension Plan as soon as possible.

WAIVING BENEFITS COVERAGE

- The Green Shield Canada EHC plan is not the same as coverage under a provincial health insurance plan.
- If another plan covers you/your dependant(s) for EHC or Dental benefits, you may waive such benefits under this plan.
- If you waive coverage, you may enroll yourself, your spouse and/or dependants at a later date only if you provide proof of continuous coverage since starting your pension. You must provide the same proof for your spouse and/or dependants if you wish to enroll them. You must apply to enroll yourself, your spouse and/or dependants within 60 days of the termination of your spouse's benefit plan.
- Failure to return this application will be treated as if you waived coverage.
- You must complete Part 1 — Applicant Information and Part 3 — Dependant Information (if applicable) even if you or your spouse and/or dependants are waiving coverage.

PART 7 — APPLICANT SIGNATURE

By signing this enrolment form or providing my personal information to my plan sponsor, I confirm that the information is complete and accurate to the best of my knowledge. I am authorized to release information concerning my spouse and my dependants, for purposes of determining eligibility for benefits and any other services necessary in the administration of my benefits. I certify that I am authorized by my spouse and/or dependants to disclose and receive information about them that is used for these purposes. I agree that Green Shield Canada may share the personal information with a third party for the administration of benefits for myself and my dependants. I agree that my email address may be used, if provided, to correspond with me for benefit purposes.

I also understand and consent to the disclosure of this personal information to my plan sponsor when required or permitted by contract between Green Shield Canada and my plan sponsor; and to the retention, use and disclosure of this personal information in accordance with Green Shield Canada's Privacy Policy. The privacy policy is available online at http://www.greenshield.ca/en-ca/privacy-policy or by calling Green Shield Canada at 1-888-711-1119.

I understand benefit coverage is a contingent benefit of the plan. That is, the EHC and dental benefits are not guaranteed. The coverage may be changed at any time by the Public Service Pension Board of Trustees, including, but not necessarily limited to, increasing, decreasing or eliminating (a) coverage for people and benefits, or (b) amounts for premiums and deductibles. If my pension payment is sufficient to cover my premium(s), I authorize the Public Service Pension Plan to deduct this amount from my pension cheque. If I should receive a settlement or a judgement against a liable third party for wage loss or benefits covered under my group plan, I agree to and authorize the third party to reimburse Green Shield Canada up to the amount advanced to me pending such settlement or judgement.

Applicant's signature	Date Signed (yyyy-mm-dd)
X	