HR Shared Services
300 Carlton St - 5th Floor
Email: HRSharedServices@wrha.mb.ca

Welcome and congratulations on your new position.

Eligibility for the employee benefits plan is based on your union affiliation and employment status; therefore, benefit eligibility may change if there is a change to your employment status.

A summary sheet of the plans are enclosed for your reference. For further information on plan details and coverage please go to http://www.hebmanitoba.ca/home/. To sign up for customer E-Service, go to https://www.mb.bluecross.ca/mybluecross.

You must complete all enrolment forms **within 30 days of employment** and the forms must be completed **correctly. You must ensure all employee sections and signature areas on the forms are completed and return original forms to**:

HR Shared Services

300 Carlton Street - 5th Floor

Winnipeg, Manitoba

R3B 2K6

Forms that are not completed correctly will be returned to you and cause further delays. Failure to return completed forms will result in restrictions to your benefits. **For example**: If you are requesting to waive your benefits due to alternate coverage, if we do not receive the request within 45 days of the life change or new enrolment you will **NOT** be permitted to waive your coverage.

The forms need to be returned immediately as some of the benefits are effective from the date of hire and contributions will need to be collected retroactively to your date of hire and deducted from your payroll in a lump sum.

If you do not complete the enrolment form you will be automatically enrolled in the default benefits.

If you have any questions or need assistance with the completion of the forms, please email: HRSharedServices@wrha.mb.ca or call 204-940-8500 or Toll Free 1-866-999-9686, option 5.

Thank you,

HR Shared Services

Please complete and return all signed original forms to:
HR Shared Services
5th Floor, 300 Carlton St
Winnipeg MB R3B 2K6

- All forms must be signed and dated in ink.
- Scanned copies will not be accepted. Originals must be submitted.
- Any changes to the forms (via white out or crossed out) must be initialed to be valid.
- All benefit enrolment forms must be submitted within 60 days of becoming eligible.

Life Insurance plan:

- Coverage begins the 1st day in a part-time or full-time position.
- Enrolment form must be submitted within 60 days of your coverage start date otherwise an Evidence of Insurability will be required for insurance above the basic coverage.

Healthcare & Dental plans:

- Coverage is mandatory unless you have alternate group coverage
- Coverage begins the 1st of the month following the date you began employment in a part-time or full-time position.
- Require that you enroll at your true family status (if you have a legal spouse or dependents, you must elect family coverage).
- The Healthcare & Dental enrolment form must be submitted within 60 days from the date of coverage begins otherwise restrictions will apply:

  Restriction #1 – If you should have family coverage, a one-year waiting period will be applied to your legal spouse and/or dependents beginning from the date that HEB receives the form.

  Restriction #2 – If you want to waive coverage; the request to waive will be denied and you will be required to remain in the plan.

D&R:

- Coverage begins the 1st day in a part-time or full-time position and is mandatory for all full-time or part-time employees.
- Enrolment forms must be submitted within 60 days of your coverage start date otherwise Evidence of Insurability will be required.

Pension plan:

- Mandatory at 2 years of service.
- You may join immediately or at any time prior to the completion of 2 years of service.

Employee Assistance Plan:

- Entitles employees and family members access to free and confidential counseling if desired. An enrolment form is required to be signed.

HEB Manitoba website: www.hebmanitoba.ca
HEB Manitoba (Member Services) phone: 204-942-6591

MANITOBA HEALTHCARE BENEFITS SUMMARY

Pension Plan:

- **ER Physicians do not participate**
- Eligibility - *All* employees are eligible to join immediately and it is mandatory to join after 2 years.
- Contributions are 7.9% up to the Canada Pension Plan Yearly Maximum Pensionable Earnings and 9.5% on excess. Employer contributes to the fund.
- Defined benefit pension plan – guaranteed lifetime pension based on a combination of earnings history and contributory service.

Disability & Rehabilitation (LTD):

- **ER Physicians do not participate.**
- Eligibility – Mandatory full and part-time, permanent and term employees.
- Coverage effective date of hire.
- Premiums – Employer paid at 2.2%. Some Unions cost share EE 1% ER 1.2%.
- Monthly Benefit (Taxable) = 66 2/3% of basic hourly rate x average monthly hours worked.

Group Life Insurance:

- Eligibility – Full and part-time permanent and term employees.
- Coverage effective date of hire.
- Basic = 1 x annual wage based on prior year earnings OR EFT at time of hire. Employer Paid.
- Optional Life = 1 to 4 units x annual wage based on prior year earnings OR EFT at time of hire. Employee paid .0826 cents per $1000 of coverage.
- Optional Family = 1 to 10 units, Employee paid. Coverage per unit for spouse is $10,000 (maximum 100,000) and $5.000 (maximum 50,000) for each dependant.
- AD&D included on basic, optional and family coverage.

Dental

- Eligibility – Full and part-time, permanent and term employees.
- Coverage effective 1st of the month date of hire.
- Mandatory for all eligible employees to join unless covered under another group plan.
- Cost = Single - $19.47 per month. Family - $56.82 per month**.** Employer matched.
- Coverage: 100% eligible basic treatment
  50% eligible major treatment
  50% eligible orthodontic treatment of $1250 lifetime maximum – dependent children under age 18.
  Any charges incurred are included in annual maximum.
- Payment basis – Current Dental Association fee guide.
- Policy year – January 1 – December 31.
- Maximum benefit $1250/person per policy year.
- Pre-approval for claims over $500

Extended Health Care:

- Eligibility – Full and part-time, permanent and term employees.
- Coverage effective 1st of the month following date of hire.
- Mandatory for all eligible employees to join. May waive participation due to coverage under another group plan.
- Cost = Single - $19.16 per month. Family - $47.82 per month**.** Employer matched.
- Must enroll based on true family status (single or family)
- 60 day rule to make status changes from date of major life event – marriage, death or loss of coverage from another group plan.

Employee Assistance Plan:

- Eligibility – All employees are eligible to join at no cost.
- Confidential counseling services administered by the Blue Cross Employee Assistance Centre.

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HEB Manitoba
HEALTHCARE EMPLOYEE BENEFIT PLANS

Authorization to Collect, Use & Disclose Personal Information

Employee Name: _____ _____ _____
Last name First name Middle initial

Employee SIN: _____
For identification purposes

I understand that:

- Personal information and personal health information will be collected from me for the purpose of administering the Healthcare Employees' Pension Plan - Manitoba (HEPP) and the Healthcare Employees' Benefits Plan - Manitoba (HEBP), which includes the Healthcare, Life Insurance, Dental, Disability & Rehabilitation, and Retiree Healthcare Plans. This includes enrolling members, appointing beneficiaries, determining my eligibility and entitlement, if any, to benefits, and processing my benefits, if any (hereinafter, the "Identified Purpose").
- For the Identified Purpose, it may be necessary to collect my personal information and personal health information from and disclose my personal information and personal health information to individuals and organizations acting on behalf of HEPP and HEBP, such as: *staff of HEPP and HEBP; actuaries; lawyers and physicians, as well as other individuals and entities, such as my physicians, my employer(s), my healthcare providers, other insurers and government regulators.*
- The privacy of individuals about whom the information relates and the confidentiality of personal information collected will be protected in accordance with relevant privacy policies and privacy law(s).
- I may withdraw all or part of my consent at any time, in writing, but that doing so may interfere with fulfilling the Identified Purpose and may result in a delay in processing my application for benefits or may result in my benefits being declined, in whole or in part.

I, _____ (please print name) **authorize the administrator(s) of HEPP and HEBP, and the individuals and organizations authorized to act on their behalf, to collect, use and disclose my personal information and my personal health information for the Identified Purpose. A reproduction of this authorization is as valid as the original.**

Employee Signature: _____ Date Signed: _____ | _____ | _____
DD MMM YYYY

Please direct any privacy related questions, comments or requests to:

Chief Privacy Officer
HEB Manitoba
900-200 Graham Avenue
Winnipeg MB R3C 4L5
Email: privacy@hebmanitoba.ca
Phone: (204) 975-3197 Toll-free: 1-855-975-3197

Form Return

Please return the completed form to the representative in your facility/RHA responsible for benefits, e.g., the Human Resources or Payroll Department. Your employer representative will submit your form to HEB Manitoba, 900-200 Graham Avenue, Winnipeg MB R3C 4L5.

CLEAR FORM

HEB Manitoba Use Only

HEB Manitoba
HEALTHCARE EMPLOYEE BENEFIT PLANS

Pension Plan
Enrolment Form

Employee: All sections of this form must be completed. If the form is incorrect or incomplete, the form will be returned to your employer. You must initial any correction(s) made to Sections 4 and 6 of this form. Failure to do so may delay enrolment or result in your beneficiary designation reverting to your Estate. **Please print clearly in blue ink.**

Section 1: Employee Information

Employee Name: _____ (Last name) _____ (First name) _____ (Middle initial)

Mailing Address: _____ _____ (City/Town) _____ (Province) _____ (Postal code)

Employee SIN: _____ (For identification purposes) Birth Date: _____ | _____ | _____ (DD | MMM | YYYY) Gender: ☐ Male ☐ Female

Employee Phone Number: _____ Cell: _____ Personal Email Address: _____

Section 2: Marital Status Information **Please refer to the definition of a common-law relationship on our website at hebmanitoba.ca.**

Marital Status: ☐ Single ☐ Married ☐ Common-Law Relationship ☐ *Separated/Divorced ☐ Widowed

Spouse/Common-Law Partner Name: _____ (Last name) _____ (First name) _____ (Middle initial)

Spouse/Common-Law Partner Birth Date: _____ | _____ | _____ (DD | MMM | YYYY) Date of Marriage: _____ | _____ | _____ (DD | MMM | YYYY) Date of Cohabitation: _____ | _____ | _____ (DD | MMM | YYYY)

*Date of Separation: _____ | _____ | _____ (DD | MMM | YYYY) Former Spouse/Common-Law Partner Name: _____ (Last name) _____ (First name) _____ (Middle initial)

if applicable

Section 3: Employment Information **To be completed by the employer representative before providing the form to the employee.**

Employer Name: _____ Employer Number: _____

Employment Date: _____ | _____ | _____ (DD | MMM | YYYY) Union/Non-Union Code: _____ Base Hours: _____

Employee ID #: _____ (For facility identification purposes) Employment Status: ☐ Full-time ☐ Part-time ☐ Casual ☐ Student

Section 4: Enrolment Options **To be completed by the employee. You must choose one of the following 4 options.**

☐ **Mandatory Enrolment** I understand that I must join the Healthcare Employees' Pension Plan (HEPP) immediately if any of the following statements apply:

- I am reinstating my prior service. If my *Pension Enrolment* form is not completed and received by my employer within 30 days of my date of employment, my enrolment in HEPP will be on a go forward basis, unless contributions have already been remitted.
- I am transferring service in as a Reciprocal/CV Transfer. (Complete Section 5)
- I have been employed for two continuous years, which includes any breaks in employment service of 31 days or less, with one or more HEPP participating employers.
- I am concurrently working at another participating employer where I am a member of HEPP. I must contribute with all participating employers that I am employed with at the same time.
- I am employed/re-employed within 31 days from my termination date with my previous employer where I was a participating member of HEPP.

Previous Participating Employer (if applicable): _____ Termination Date: _____ | _____ | _____ (DD | MMM | YYYY)

☐ **Voluntary Enrolment** I understand that I may voluntarily join the Healthcare Employees' Pension Plan (HEPP)

I choose to voluntarily join HEPP. If my *Pension Enrolment* form is not completed and received by my employer within 30 calendar days of my date of employment and received by HEB within the following 10 business days, my enrolment in the Pension Plan will be on a go forward basis, unless contributions have already been remitted.

☐ **Temporarily Waive Enrolment** I understand that I may temporarily waive enrolment in the Healthcare Employees' Pension Plan (HEPP)

I choose to waive joining HEPP as I do not meet any of the mandatory enrolment provision(s). I may voluntarily join at any time but must join the Pension Plan when I have two years of continuous employment with one or more participating employers.

☐ **Receiving a HEPP Monthly Pension** Returned to work after retirement

If I receive a monthly pension from the same employer Registered Pension Plan (RPP), the *Income Tax Act* regulations prohibit me, as a member of that RPP, from contributing at the same time.

- I currently receive a monthly pension benefit from the Healthcare Employees' Pension Plan (HEPP); and am eligible to join the plan.

I understand and comply with this policy by selecting: (please check only one option below).

☐ I want to join and contribute to HEPP and **stop** receiving my monthly HEPP pension. I understand that my monthly pension payments will stop and restart at the date I subsequently retire.

☐ I do **not** want to join HEPP; I want to continue receiving my HEPP monthly pension payments.

Section 5: Transferring in a Pension Benefit

If you were a member of a Registered Pension Plan (RPP) with your former employer you may be eligible to transfer your pension benefit to HEPP.

☐ **Transfer of pension benefit:** I would like information about transferring the pension benefit I have at another RPP.

Name of other Registered Pension Plan: _____ Termination Date: _____ | _____ | _____
DD MMM YYYY

You must start contributing to HEPP immediately to be eligible to transfer in a pension benefit from another RPP.

Section 6: Beneficiary Designation **To be completed by the employee upon enrolment.** Future changes must be made through *My HEB Online Services* at hebmanitoba.ca.

I, the above named employee hereby revoke any previous beneficiary designation(s) and appoint the following as the beneficiary(ies) of any monies payable upon my death under the Healthcare Employees' Pension Plan (HEPP) administered by HEB Manitoba. I understand that if I am married or in a common-law relationship, my beneficiary must be my spouse or common-law partner, unless they waive entitlement to the death benefits, allowing me to choose another beneficiary. Please contact HEB Manitoba for further instructions, if your spouse/common-law partner wishes to waive entitlement to the HEPP death benefits.

Note: Unless the law requires otherwise, the entitlement of any beneficiary who predeceases me will revert to my surviving beneficiary(ies) in equal shares, or if there is no surviving beneficiary(ies), the entitlement will revert to my Estate.

Please print the last and first name of each beneficiary in the lines provided below or if selecting your spouse/common-law partner or Estate please check off the appropriate box.

☐ 100% to my spouse/common-law partner, or
☐ 100% to my estate, or
☐ as outlined below:

Whole numbers must be used and the total percentage must equal 100%. If the total percentage does not equal 100%, your beneficiary will remain defaulted to your estate or previously listed pension beneficiary on file.

Beneficiary(ies)

Last name	First name	Birth Date (DD/MMM/YYYY)	Relationship to employee	Percentage

Total = 100%

If designating a beneficiary who is a minor or who lacks legal capacity, you must appoint a Trustee. Do not complete the following Trustee information if you have already appointed a Trustee in any legal document. **If you are designating a Trustee, we recommend you first consult with the proposed Trustee and a legal advisor.**

If any beneficiary is under 18 or lacks legal capacity at the time of my death, I appoint the individual named below as Trustee to receive and hold in trust all benefits payable to any beneficiary designated hereunder who at the time benefits are paid is a minor or lacks legal capacity to give a valid discharge. Payment of the benefits to the Trustee discharges HEB Manitoba to the extent of payment. The trust will terminate when the beneficiary is of the age of majority and has legal capacity.

I appoint as Trustee:

Last name	First name	Birth date (DD/MMM/YYYY)	Relationship to employee

Section 7: Employee Authorization and Signature

I hereby acknowledge that I have read and understand the terms and conditions of the Plan as outlined in the Plan brochure and I know what the current contribution rates are and confirm the option(s) chosen above. I understand that once contributions are deducted, I cannot change my election to participate.

I also authorize the administrators of HEB Manitoba, and the individuals and organizations authorized to act on their behalf, to collect, use and disclose my personal information and my personal health information for the purpose of administering the Plans. (For a copy of the HEB Manitoba's *Privacy Policy* or for further information about our privacy practices, please visit the *Privacy* section of our website at hebmanitoba.ca.)

Employee Signature: _____ Date Signed: _____ | _____ | _____
DD MMM YYYY

Employee Name: _____
Please print

Section 8: Employer Authorization and Signature **To be completed by the employer representative.**

I hereby confirm the information above is accurate, and the appropriate contributions will be deducted and remitted by the participating employer.

Employer Representative Signature: _____ Date Signed: _____ | _____ | _____
DD MMM YYYY

Employer Representative Name: _____
Please print

If HEB Manitoba does not receive this form for the noted member within 10 business days from the date they submit it to you, it will be considered to be a late enrolment.

Form Return

Please return the completed form to the representative in your facility/RHA responsible for benefits, for example, the Human Resources or Benefits/Payroll Department. Your employer representative will submit your form to HEB Manitoba, 900-200 Graham Avenue, Winnipeg MB, R3C 4L5.

CLEAR FORM

HEB Manitoba Use Only

HEB Manitoba
HEALTHCARE EMPLOYEE BENEFIT PLANS

Disability & Rehabilitation Plan

Enrolment Form

Section 1: Employee Information

Employee Name: _____ _____ _____
Last name First name Middle initial

Employee SIN: _____ Birth Date: _____ | _____ | _____ Employee ID Number: _____
For identification purposes DD MMM YYYY

Mailing Address: _____ _____ _____ _____
City/Town Province Postal code

Section 2: Employment Information

To be completed by the employer representative.

Employer: _____ RHA: _____ (if applicable)

Facility Number: _____ RHA Number: _____ (if applicable)

Employment Date: _____ | _____ | _____ (first day of employment)
DD MMM YYYY

Section 3: Enrolment Type

To be completed by the employer representative.

Note: If employee is transferring their D&R coverage within 30 days of termination of employment/coverage, (or when specifically provided for in a Collective Agreement applicable to the Covered Employee, within 42 days) complete the *Disability & Rehabilitation Plan Transfer of Coverage Form*.

Please review the attached descriptions and check one.

❑ Newly Hired Employee

❑ Employment Status Change

Date of Status Change: _____ | _____ | _____
DD MMM YYYY

Type of Status Change: ❑ Casual to part-time
❑ Casual to full-time
❑ Employee group not covered by D&R to covered employee group

❑ Employer/Employee Group Joins the D&R Plan: Employee Actively at Work or Absent due to Paid Vacation or Scheduled Day Off

Employee Group Participation Date: _____ | _____ | _____ (Date Employer/Employer Group Joined D&R Plan)
DD MMM YYYY

❑ Employer/Employee Group Joins the D&R Plan: Employee Absent due to Reason Other than Paid Vacation or Scheduled Day Off

Date Employee returned to work (full duties and normal level of hours): _____ | _____ | _____
DD MMM YYYY

❑ Late Enrolment (Evidence of Insurability is required if this form is signed by the employee or employer representative after 60 calendar days from the Effective Date of Coverage, or if the completed *Enrolment Form* is received by HEB Manitoba after the deadline. Attach a copy of the first page of the *Evidence of Insurability* form to the completed original *Enrolment Form*).

Evidence of Insurability was sent to Employee: ❑ No ❑ Yes Date Sent: _____ | _____ | _____
DD MMM YYYY

If Yes, attach a copy of the first page of the *Evidence of Insurability* form.

*If required, attach additional information in writing, with form.

Section 4: Effective Date of Coverage

To be completed by the employer representative.

Effective Date of Coverage: _____ | _____ | _____
DD MMM YYYY

Note: The Effective Date of Coverage is the first day of coverage. The completed *Enrolment Form* must be signed by the employee and employer within 60 calendar days of the Effective Date of Coverage.

Section 5: Employee Authorization and Signature

I hereby:

1. Acknowledge that I have read and understand the terms and conditions of the D&R Plan as outlined in the *Understanding Your Disability & Rehabilitation Benefits* brochure and that I am subject to the Pre-Existing Condition Limitation. (To view the brochure visit the Disability & Rehabilitation section of our website at hebmanitoba.ca.)
2. Understand that my enrolment in the D&R Plan is a condition of employment however; if I previously opted out of the D&R Plan, if I was denied coverage due to evidence of insurability or I did not complete the evidence of insurability process, if I am part of an employee group that does not participate in the D&R Plan or I am age 64 and eight months or older, I am not eligible to enrol and my application will be denied.
3. Understand that if I am not actively working, I will not be eligible to enrol until I return to work. When you return to work, contact your Employer to complete the enrolment process.
4. Authorize HEB Manitoba to collect, use and disclose my personal information for the purpose of administering the HEB Manitoba Plans. (For a copy of HEB Manitoba's *Privacy Policy* or for further information about our privacy practices, please visit the Privacy section of our website at hebmanitoba.ca.)

Employee Signature: _____ Date Signed: _____ | _____ | _____
DD MMM YYYY

Employee Name: _____
Please print

Section 6: Participating Employer Authorization and Signature

I hereby confirm the information above is accurate.

Employer Representative Signature: _____ Date Signed: _____ | _____ | _____
DD MMM YYYY

Employer Representative Name: _____
Please print

Form Return

Employee

Please submit the completed original form to the representative in your facility/RHA responsible for benefits, e.g. Human Resources or Payroll Department. Your employer representative will submit your form to HEB Manitoba.

Employer Only

Please submit completed original form to:

Disability & Rehabilitation Department
HEB Manitoba
1000-200 Graham Avenue
Winnipeg MB R3C 4L5

HEB Manitoba Use Only

Form Reviewed: _____
HEB ID: _____
Signature: _____
Reviewed: _____

HEB Manitoba
HEALTHCARE EMPLOYEE BENEFIT PLANS

Disability & Rehabilitation Plan

Enrolment Form Information Sheet

Description of Enrolment Types

Newly Hired Employee:
An employee who is newly hired by a Participating Employer.

To enrol in the D&R Plan, the employee must:

a) Be employed within an employee group that participates in the D&R Plan and

b) Work full-time (permanent or temporary/term) or part-time (permanent or temporary/term).

Effective Date of Coverage: Coverage starts on the day the employee commences Active Service.*

Employment Status Change:
An employee who previously was not eligible to participate in the D&R Plan but due to an employment status change is now eligible.

To enrol in the D&R Plan, the employee must:

a) Be employed within an employee group that participates in the D&R Plan and

b) Work full-time (permanent or temporary/term) or part-time (permanent or temporary/term).

Effective Date of Coverage: Coverage starts on the day the employee commences Active Service in the eligible position.

Employer/Employee Group Joins the D&R Plan -
Employee Actively at Work on the Employee Group Participation Date or Absent due to Paid Vacation or Scheduled Day Off:
An employee who was Actively at Work (full duties and normal level of hours) or absent due to paid vacation or scheduled day off on the Employee Group Participation Date.

To enrol in the D&R Plan, the employee must:

a) Have been hired prior to the Employee Group Participation Date,

b) Be employed within an employee group that participates in the D&R Plan,

c) Work full-time (permanent or temporary/term) or part-time (permanent or temporary/term), and

d) Be Actively at Work (full duties and normal level of hours) or absent due to paid vacation or scheduled day off on the Employee Group Participation Date.

Effective Date of Coverage: Coverage starts on the Employee Group Participation Date (date the employer/employee group joins the D&R Plan).

Note: Employee Participation Date is the date the employer/employee group joins the D&R Plan.

Employer/Employee Group Joins the D&R Plan -
Employee Absent on the Employee Group Participation Date due to Reason Other than Paid Vacation or Scheduled Day Off:
An employee who was absent on the Employee Group Participation Date for a reason other than paid vacation or scheduled day off.

To enrol in the D&R Plan, the employee must:

a) Have been hired prior to the Employee Group Participation Date,

b) Be employed within an employee group that participates in the D&R Plan,

c) Work full-time (permanent or temporary/term) or part-time (permanent or temporary/term),

d) Be absent on the Employee Group Participation Date for a reason other than paid vacation or scheduled day off, and

e) Return to full duties and normal level of hours.

Effective Date of Coverage: Coverage starts on the day the employee commences Active Service.

Enrolment Form Deadline:
Both the employee and the employer representative must sign the *Enrolment Form* within 60 days of the date the employee becomes eligible for coverage (Effective Date of Coverage).

To allow for mailing, HEB Manitoba will accept original *Enrolment Forms* received within 10 business days from the 60-day deadline.

Late Enrolment:
If the *Enrolment Form* is signed and/or received by HEB Manitoba after the *Enrolment Form* deadline the enrolment will be considered late and the employee will be required to provide Evidence of Insurability.

Effective Date of Coverage: The Effective Date of Coverage will be established upon approval of Evidence of Insurability.

For more information, please read the D&R Late Enrolment/Evidence of Insurability section of the *Employer Administration Manual*.

Important:
It is important that the employee read the *Understanding Your Disability & Rehabilitation Benefits* brochure as it provides information about the D&R Plan.

The information provided in this document is intended to be general. In the event a discrepancy or misunderstanding arises, the *Disability and Rehabilitation Plan Text* is the final authority concerning the administration of the D&R Plan.

***Note:** Active Service means in the performance of the Material and Substantial Duties of the employee's Regular Occupation at the normal level of hours for which they were hired.

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HEB Manitoba Use Only

HEB Manitoba
HEALTHCARE EMPLOYEE BENEFIT PLANS

Life Insurance Plan
Enrolment Form

This form must be completed for:
- *A newly hired employee who is eligible to participate in the Life Insurance Plan;*
- *An employee with an employment status change who becomes eligible to participate in the Life Insurance Plan; or*
- *An employee returning to work from an approved leave of absence (LOA) that started prior to December 1, 2012.*

All sections of this form must be completed. If the form is incorrect or incomplete, the form will be returned to the employer. Any correction(s) made to Sections 4 and 5 of this form by the employee must be initialled by the employee. **If completing this form manually, please print clearly in INK.**

Note: This form must be signed within 60 calendar days of employment start date in an eligible position or date employee returned to work from an approved LOA that started prior to December 1, 2012, and must be received within 10 business days.

Section 1: Employee Information

Employee Name: _____ (Last name) _____ (First name) _____ (Middle initial)

Mailing Address: _____ _____ (City/Town) _____ (Province) _____ (Postal code)

Employee SIN: _____ (For identification purposes) Birth Date: _____ | _____ | _____ (DD | MMM | YYYY) Gender: ❑ Male ❑ Female

Section 2: Employment Information

To be completed by the employer representative prior to providing the form to the employee.

Employer Name: _____ Employer Number: _____

Employee ID Number: _____ (For facility identification purposes)

Hourly Rate: $ _____ x Annual Base Hours: _____ x EFT: _____ = Estimated Annual Earnings: $ 0.00 (EFT Earnings) = Unit Value: $ 0 (EFT earnings rounded up to the next $1,000)

Examples:

Full-time Employee: hourly rate $20.12 x annual base hours 1950 x EFT 1.0 = $39,234.00. Round up to next $1,000 = $40,000 Unit value.
Part-time Employee: hourly rate $20.12 x annual base hours 1950 x EFT 0.7 = $27,463.80. Round up to next $1,000 = $28,000 Unit value.

Section 3: Enrolment Type

To be completed by the employer representative.

❑ **New Employee Enrolment**

Employment Date: _____ | _____ | _____ (DD | MMM | YYYY)

❑ **Employment Status Change**

Type of status change: ❑ Casual to part-time ❑ Casual to full-time ❑ Employee transferred to a union group covered under the Plan

Employment Date: _____ | _____ | _____ (DD | MMM | YYYY) Date of Status Change: _____ | _____ | _____ (DD | MMM | YYYY)

❑ **Employee Returned to Work from an Approved Leave of Absence (LOA) That Started Prior to December 1, 2012**

Return to Work Date: _____ | _____ | _____ (DD | MMM | YYYY)

Section 4: Life Insurance Coverage

To be completed by the employee. Any corrections must be initialled by the employee.

Basic Life Insurance Coverage (No election required)

1 Unit of Basic Life Insurance = $ 0 (This is the Unit value from Section 2)

The HEB Manitoba Life Insurance Plan automatically insures you for 1 unit of insurance paid by your employer. You are automatically provided with Accidental Death & Dismemberment (AD&D) coverage equal to your Basic Life Insurance. This AD&D coverage is provided at no additional cost to you.

Optional Life Insurance

Each Unit of Optional Life Insurance = $ 0 /1000 x 0.0826 = $ 0.00 (This is your biweekly premium per unit of coverage.)

You may choose up to a maximum of 4 units of Optional Life Insurance. You are automatically provided with Accidental Death & Dismemberment (AD&D) coverage equal to your Optional Life Insurance. This AD&D coverage is provided at no additional cost to you.

Each pay period, you pay $0.0826 per $1,000 of insurance multiplied by the number of units selected, plus applicable Manitoba Retail Sales Tax.

REQUIRED: *Check ☑ ONE of the following options. One option **MUST** be selected, even if your choice is "0", otherwise the form will be returned to you.*

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4

DO NOT PROCEED UNLESS YOU HAVE CHECKED ONE OF THE BOXES ABOVE.

Family (Dependant) Life Insurance

Each Unit of Family (Dependant) Life Insurance = $2.42 (This is your biweekly premium per unit of coverage.)

You may choose up to a maximum of 10 units. Each unit is equal to $10,000 (to a maximum of $100,000) for your spouse/common-law partner and $5,000 (to a maximum of $50,000) for each eligible, dependant child. You are automatically provided with Accidental Death & Dismemberment (AD&D) coverage equal to your Optional Life Insurance. This AD&D coverage is provided at no additional cost to you.

Each pay period, you pay $2.42 per unit, plus applicable Manitoba Retail Sales Tax.

REQUIRED: *Check ☑ ONE of the following options. One option **MUST** be selected, even if your choice is "0", otherwise the form will be returned to you.*

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

DO NOT PROCEED UNLESS YOU HAVE CHECKED ONE OF THE BOXES ABOVE.

Section 5: Beneficiary Designation

To be completed by the employee.

If no beneficiary is appointed, the entitlement will revert to my Estate.

By signing this form below, I, the above named employee, hereby revoke any previous beneficiary designation(s) under the HEB Manitoba Life Insurance Plan at this employer and appoint the following as the beneficiary(ies) of any monies payable upon my death under the HEB Manitoba Life Insurance Plan. **Abbreviations and/or quotations are not valid. Crossed out, white out and/or corrections to primary, contingent beneficiary(ies) and/or trustee designations must be initialled. Failure to do so may result in the designation reverting to your Estate. Please print clearly in INK.**

Primary Beneficiary(ies)

Last name	First name	Middle Initial	Relationship to employee	Percentage

Total 100%

If all of the primary beneficiaries die before me, the death benefit set out in the Plan is paid to the contingent beneficiary(ies) as outlined below.

Contingent Beneficiary(ies)

Last name	First name	Middle Initial	Relationship to employee	Percentage

Total 100%

NOTE: Unless the law requires otherwise, the entitlement of any beneficiary who predeceases me will revert to my surviving primary beneficiary(ies) in equal shares, or if there is no surviving primary beneficiary(ies), to my contingent beneficiary(ies). If there is no appointed or surviving contingent beneficiary(ies), the entitlement will revert to my Estate.

If designating a beneficiary who is a minor or who lacks legal capacity, you may wish to appoint a Trustee. Do not complete the following Trustee information if you have already appointed a Trustee in any legal document. **If you are designating a Trustee, we recommend you first consult with the proposed Trustee and a legal advisor.**

If any beneficiary is under 18 or lacks legal capacity at the time of my death, I appoint the individual named below as Trustee to receive and hold in trust all benefits payable to any beneficiary designated hereunder who at the time benefits are paid is a minor or lacks legal capacity to give a valid discharge. Payment of the benefits to the Trustee discharges HEB Manitoba to the extent of payment. The trust will terminate when the beneficiary is of the age of majority and has legal capacity.

Trustee

Last name	First name	Middle Initial	Relationship to employee

Section 6: Employee Authorization and Signature

IMPORTANT: HEB Manitoba Life Insurance is provided on a **TERM BASIS**. Life Insurance coverage for you and, if applicable, your eligible dependants, stops on either the earlier of your date of retirement/termination, the last day premiums were payable, or when you reach age 71. However, there is a 31-day period following the termination of your coverage in which you are eligible to apply for conversion to an individual Life Insurance Policy with The Great-West Life Assurance Company (age and maximum conversion limits may apply). During this 31-day period, HEB Manitoba Life Insurance coverage will be maintained for you and your spouse/common-law partner. Please note, Employee Life Insurance provides a maximum benefit of up to $1,000,000 of Basic and Optional Life Insurance per member for all participating employers combined.

CAUTION: Your beneficiary designation by means of a designation form will not be revoked or changed automatically by any future marriage or divorce. Should you wish to change your beneficiary in the event of a future marriage or divorce, you will have to do so by means of a new designation.

I hereby:

1. Acknowledge that I have read and understand the terms and conditions of the HEB Manitoba Life Insurance Plan as outlined in the *Understanding Your Life Insurance Benefits* brochure. **All corrections in Sections 4 and 5 have been initialled.**
2. Acknowledge I have made an election for both Optional Life and Family (Dependant) Life even if it is 0.
3. Authorize the administrators of HEB Manitoba, and the individuals and organizations authorized to act on their behalf, to collect, use and disclose my personal information and my personal health information for the purpose of administering the Plans. (For a copy of HEB Manitoba's *Privacy Policy* or for further information about our privacy practices, please visit the *Privacy* section of our website at hebmanitoba.ca.)

Employee Signature: _____ Date Signed: _____ | _____ | _____
DD MMM YYYY

Employee Name: _____
Please print

Section 7: Employer Authorization and Signature

To be verified prior to signature. Please check all boxes that apply.

❑ I hereby confirm that the information above is accurate. **All corrections in Sections 4 and 5 have been initialled by the employee.**

❑ The employee has elected _____ Optional Units and _____ Family (Dependant) units and **the appropriate premiums will be remitted by the participating employer.**

❑ This form has been signed and submitted by the employee within 60 calendar days of the eligibility date.

❑ If late, an *Evidence of Insurability Application* was provided to the employee on _____ | _____ | _____.
DD MMM YYYY

Any Optional and/or Family Dependant Life Insurance units will not become effective until Evidence of Insurability is approved by the Great-West Life Assurance Company.

Employer Representative Signature: _____ Date Signed: _____ | _____ | _____
DD MMM YYYY

Employer Representative Name: _____
Please print

Form Return

Employee

Please submit completed form to the representative in your facility/RHA responsible for benefits, for example, the Human Resources or Payroll Department. Your employer representative will submit your form to HEB Manitoba, 900-200 Graham Avenue, Winnipeg MB R3C 4L5.

CLEAR FORM

HEB Manitoba Use Only

HEB Manitoba
HEALTHCARE EMPLOYEE BENEFIT PLANS

Healthcare & Dental Plans
Enrolment Form

As a condition of employment as a new employee or if your employment status changes from casual to full-time or part-time (permanent, temporary or term), you must enrol in the HEB Manitoba Healthcare and/or Dental Plans unless you have coverage under an alternate group healthcare and/or dental plan. Your coverage will commence on the first day of the month following the employment or status change. If you wish to waive coverage in the HEB Manitoba Healthcare and/or Dental Plans, you must declare your alternate coverage within 60 days of your effective date of coverage with HEB Manitoba. Please complete the applicable sections of this form and return it to your employer representative.

Section 1: Employee Information

Employee Name: _____ _____ _____
Last name First name Middle initial

Mailing Address: _____ _____ _____ _____
City Province Postal code

Birth Date: _____ | _____ | _____ ❑ Male ❑ Female
DD MMM YYYY

Employee SIN: _____ HEB Unique #: _____
For identification purposes

Section 2: Employment Information To be completed by employer representative

Employer Name: _____ Employer Number: _____

Employee ID: _____ Employment Date: _____ | _____ | _____
DD MMM YYYY

❑ Date employment status changed from casual to: ❑ Part-Time ❑ Full-Time: _____ | _____ | _____
(if applicable) DD MMM YYYY

Effective Date of Coverage: _____ | _____ | _____
DD MMM YYYY

Section 3: Enrolment Options

Please select from the following options:

New Employee	**Employment Status Change** (i.e., from casual to full- or part-time employment)	**Employee Transfer** (within 31 days)
❑ New enrolment - Healthcare [A]	❑ New enrolment - Healthcare [A]	❑ Transfer - Healthcare [A and B]
❑ New enrolment - Dental [A]	❑ New enrolment - Dental [A]	❑ Transfer - Dental [A and B]
❑ Waive due to coverage under an alternate group plan - Healthcare [C]	❑ Waive due to coverage under an alternate group Plan - Healthcare [C]	❑ Permanently opted out - Healthcare [B]
❑ Waive due to coverage under an alternate group plan - Dental [C]	❑ Waive due to coverage under an alternate group Plan - Dental [C]	❑ Waive due to coverage under an alternate group Plan - Healthcare [B and C]
		❑ Waive due to coverage under an alternate group Plan - Dental [B and C]

A. Coverage Type: Single or Family Coverage

You must enrol in family coverage if you have a spouse/common-law partner and/or dependant children.

❑ Single coverage ❑ Family coverage (married/common-law/children)

Spouse/Common-law Information

Your spouse is defined as the person who is legally married to you. In the case of separation, the former spouse is no longer eligible for coverage.

Your common-law partner is defined as the person who has continuously resided with you for at least one full year, and whom you have represented as your conjugal partner. You must provide the Date of Cohabitation on the Enrolment form. The date of cohabitation is the date on which you **begin** living together.

If you have lived together for less than one year at the time of enrolment, you must enrol in family coverage and declare your common-law partner, although he or she will not be eligible for coverage until you have lived together for one year. The date of coverage for your common-law partner will be the first day of the month following the one-year anniversary of cohabitation.

(Note: Unless you have other eligible family members, you will pay premiums for single coverage until your partner becomes eligible for coverage.)

Name: _____ _____ _____ ❑ Male ❑ Female
Last name First name Middle initial ❑ Does not reside in Canada

Birth Date: _____ | _____ | _____ Date of Marriage: _____ | _____ | _____ Date of Cohabitation: _____ | _____ | _____
DD MMM YYYY DD MMM YYYY DD MMM YYYY

Dependant Information

Please see the Healthcare Plan/Dental Plan/Healthcare Spending Account brochure for further information on eligible family members. Dependant children must be unmarried AND under age 21; under age 25 and attending an accredited educational institute, college or university full-time; or age 21 or older and dependent on you because of a mental or physical infirmity if the disability began before age 21 or before age 25 if a full-time student. (Further documentation may be requested.)

Please list dependant children:

Last Name	First Name	Initial	Date of Birth DD | MMM | YYYY	Male	Female	Relationship	Full-time Student	Disabled	Does Not Reside in Canada
			| |	❑	❑		❑	❑	❑
			| |	❑	❑		❑	❑	❑
			| |	❑	❑		❑	❑	❑
			| |	❑	❑		❑	❑	❑
			| |	❑	❑		❑	❑	❑

B. Employment Transfer Information

You are considered a transferring employee if you terminate with an employer with whom you had HEB Manitoba Healthcare and/or Dental Plan coverage, and you again become eligible for both or either of these benefits with the same or another employer within 31 days. Please complete the following:

Transferred From - Employer Name: _____ Employment End Date: _____ | _____ | _____
DD MMM YYYY

Date of Last Premium Deduction: _____ | _____ | _____
DD MMM YYYY

Indicate the enrolment options you elected with your previous employer:

❑ Single Healthcare coverage ❑ Family Healthcare coverage ❑ Waived Healthcare due to coverage under an alternate group plan ❑ Permanently opted-out of Healthcare Plan

❑ Single Dental coverage ❑ Family Dental coverage ❑ Waived Dental due to coverage under an alternate group plan

C. Waive Due to Coverage Under Alternate Group Plan(s)

I understand the terms and conditions of the HEB Manitoba Healthcare Plan, which includes a Healthcare Spending Account (HSA) and/or Dental Plan being offered to me, but I decline participation at this time because I am insured under an alternate group healthcare and/or dental plan. I understand that if I lose my coverage under the alternate group plan(s), I must apply for coverage under the HEB Manitoba Plan(s) within 60 days of the date of loss of coverage or benefit restrictions will apply.

❑ I want to waive participation in the HEB Manitoba Healthcare Plan which includes the HSA ❑ I want to waive participation in the HEB Manitoba Dental Plan

Please provide the following information for the alternate group plan(s):

Alternate Healthcare Coverage Provider: _____

Plan Number: _____ Effective Date of Coverage: _____ | _____ | _____
DD MMM YYYY

Alternate Dental Coverage Provider: _____

Plan Number: _____ Effective Date of Coverage: _____ | _____ | _____
DD MMM YYYY

Section 4: Employee Authorization and Signature Required

I hereby acknowledge I have read and understand the terms and conditions of the Plans as outlined in the Healthcare Plan/Dental Plan/Healthcare Spending Account brochure, and confirm the option(s) chosen above. Furthermore, I hereby authorize the administrators of HEB Manitoba, and the individuals and organizations authorized to act on their behalf, to collect, use and disclose my personal information and my personal health information for the purpose of administering the Plans. This includes enrolling members, appointing beneficiaries, determining my eligibility and entitlement, if any, to benefits, and processing my benefits.

❑ **I certify that I have declared my true family status** (required)

Employee Signature: _____ Date Signed: _____ | _____ | _____
DD MMM YYYY

Section 5: Employer Authorization and Signature Required

I am aware this employee is electing to either enrol in or waive coverage in the HEB Manitoba Healthcare and/or Dental Plans according to the information provided above, and I confirm that the appropriate premium deductions, if applicable, will be made.

Employer Representative Signature: _____ Date Signed: _____ | _____ | _____
DD MMM YYYY

❑ Automatic Enrolment (employee forced-on by employer)

Form Return:

Please submit completed form to the representative in your facility/RHA responsible for benefits, e.g., the Human Resources or Payroll Department. Your employer representative will submit your form to HEB Manitoba, 900-200 Graham Avenue, Winnipeg, MB R3C 4L5.

MANITOBA BLUE CROSS®

PO BOX 1046 STN MAIN WINNIPEG MB R3C 2X7
TEL 204.775.0151 Fax 204.772.1231

INDIVIDUAL ENROLLMENT FOR THE PROVINCIAL HEALTHCARE WORKERS'

EMPLOYEE ASSISTANCE PLAN

THIS SECTION TO BE COMPLETED BY EMPLOYEE

LAST NAME	FIRST NAME	EMPLOYEE DATE OF BIRTH (DD MM YYYY)

MAILING ADDRESS - STREET/BOX NUMBER	CITY OR TOWN	PROVINCE	POSTAL CODE

PHONE NUMBER HOME WORK	GENDER ☐ MALE ☐ FEMALE	SOCIAL INSURANCE NUMBER

PLEASE COMPLETE THIS SECTION IF YOU HAVE ELIGIBLE DEPENDENTS

☐ SPOUSE ☐ COMMON LAW	LAST NAME (if different than employee's)	FIRST NAME	DATE OF BIRTH (DD MM YYYY)	GENDER ☐ MALE ☐ FEMALE

IF APPLICANT AND SPOUSE ARE NOT LEGALLY MARRIED PLEASE PROVIDE COMMENCEMENT DATE OF COHABITATION (DD/MM/YYYY)_____

UNMARRIED DEPENDENT CHILDREN:

LAST NAME (if different than employee's)	FIRST NAME	RELATIONSHIP	DATE OF BIRTH (DD MM YYYY)	GENDER ☐ MALE ☐ FEMALE
				☐ MALE ☐ FEMALE
				☐ MALE ☐ FEMALE
				☐ MALE ☐ FEMALE
				☐ MALE ☐ FEMALE
				☐ MALE ☐ FEMALE
				☐ MALE ☐ FEMALE

IF COVERAGE FOR THE EMPLOYEE ASSISTANCE PLAN EXISTS THROUGH ANOTHER FACILITY/REGION PLEASE PROVIDE DETAILS

NAME OF FACILITY	REGION	CERTIFICATE NUMBER

YOU ARE CONSIDERED A TRANSFERRING EMPLOYEE IF YOU TERMINATE EMPLOYMENT WITH AN EMPLOYER WITH WHOM YOU HAVE HAD THE EAP PLAN, AND YOU AGAIN BECOME ELIGIBLE WITH THE SAME OR ANOTHER EMPLOYER WITHIN 90 DAYS. PLEASE RETURN THIS FORM TO YOUR HUMAN RESOURCES DEPARTMENT UPON COMPLETION.

PLEASE COMPLETE THE FOLLOWING

TRANSFERRED FROM (NAME OF FACILITY)	EMPLOYMENT END (DATE)

☐ I certify the above information is true and correct and that all participants are eligible for coverage per the group agreement. I understand that it is my responsibility to notify Manitoba Blue Cross immediately if a participant no longer meets the criteria to remain on my plan. I have read and understood the Authorization & Consent on the reverse side of this form and agree to the conditions of the group agreement between my employer and Manitoba Blue Cross.

EMPLOYEE SIGNATURE_____ DATE_____

THIS SECTION TO BE COMPLETED BY EMPLOYER

NAME OF FACILITY	REGION	FACILITY NUMBER	DATE OF HIRE (DD MM YYYY)
			☐ FULL TIME
I HEREBY CERTIFY THIS EMPLOYEE MEETS THE CONTRACTUAL REQUIREMENTS OF BEING AN ELIGIBLE EMPLOYEE	COMPLETED FOR EMPLOYER BY		☐ PART TIME
			☐ CASUAL

BLUE CROSS USE ONLY

GROUP NUMBER	ROLL	COVERAGE EFFECTIVE (DD/MM/YYYY)	CERTIFICATE NUMBER
9000			

AUTHORIZATION AND CONSENT

I understand that the personal information provided herein as well as any other personal information currently held or collected in the future by Manitoba Blue Cross may be collected, used, or disclosed to administer the terms of the group policy of which I am an eligible member, to develop and recommend suitable products and services to me, and to manage the Company's business.

Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These third parties include other Blue Cross Plans, health care professionals or institutions, health and life insurers, government and regulatory authorities, and other third parties when required to administer the benefits outlined in my policy or the group policy of which I am an eligible member.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, the coverage may be denied or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding Manitoba Blue Cross's privacy policies I can contact Manitoba Blue Cross at 204.775.0151 or 1.800.873.2583 or www.mb.bluecross.ca should I have questions as to the collection, use or disclosure of my personal information.

I authorize Manitoba Blue Cross to collect, use and disclose my personal information as described above.