Benefits Enrollment and Change Form

Policy Numbers: Health/Dental/Vision - 014098 | Group Life – 50813 | VADD – 50813

Please complete each required field prior to printing. Once completed, print and sign this form. You may e-mail it to askpb@yorku.ca or you may send it to the Pension & Benefits Office in the Department of Human Resources. Claims will only be processed for a spouse and/or dependents who are on file. **You may be enrolled into only one group of benefits whether you are active or a retired member of the University. Not all benefit plans may apply to you.**

Incorrect or incomplete enrollment information could result in denial or improper payment of your claims. Incomplete forms will be returned to you. If approved, you and/or your dependents, if applicable, will have coverage **effective the date** the Pension & Benefits Office receives the fully completed form or the date of hire whichever is later.

Employee Last Name	**Employee First Name**	**Employee ID (also referred to as member, certificate or payroll ID)**

Benefits Effective Date: _____

Extended Health: Single ☐ Family ☐ **Dental**: Single ☐ Family ☐ **Vision:** Single ☐ Family ☐*

* **For the cost of family vision go to yu link>Employee Resources>Forms and Documents>Employee Benefit Rate Chart**

Family vision is effective the first of the month, cannot be backdated and once enrolled if you cancel family vision you can reinstate coverage only in the event of a change in marital status or if your spouse's coverage at their place of employment ceases. Documentation will be required.

Do you and/or your dependents have valid Provincial Health Insurance (i.e. OHIP)? Yes ☐ No ☐ **If no, please e-mail askpb@yorku.ca**

I have read the eligibility definitions below and the following dependents are eligible for benefit coverage under the York University program in which I am enrolled. **Proof of Relationship required for spouse and/or child(ren) - See below.**

Dependent	**Last Name**	**First Name**	**Birth date (mm/dd/yyyy)**	**Disabled (Y/N)**	**Gender (M/F)**	**Action A = add D = delete**
Spouse						
Child						
Child						
Child						
Child						
Child						
Identify if your spouse is enrolled in their own group plan for **Coordination of Benefits (COB).** If yes, indicate single/family coverage **Extended Health:** Single ☐ Family ☐ **Dental:** Single ☐ Family ☐						

Coordination of Benefits – refer to your benefits booklet for more information: http://retire.info.yorku.ca/third-page/

Spouse/dependent(s) will be added effective the date the necessary proof has been received or date of hire, whichever is later. Any one of the following proof of relationship documents will be accepted:

Spouse - Your spouse by marriage or under any other formal union recognized by law, or your partner who is publicly represented as your spouse, is an eligible dependent. You can only cover one spouse at a time**.**

- Copy of marriage certificate, mail with same address as employee, proof of joint bank account or a signed declaration by both parties that you are in a conjugal relationship for a period of not less than one year

Children - Unmarried children (including stepchildren, legally adopted children and children of common-law spouse during the time that coverage for the spouse is in effect), who are under 21 years of age and depend on you for support; who are between the ages of 21 and 25 dependent on you for support and attending an institution of higher learning as a full-time student; or any age and are permanently mentally or physically disabled and incapable of self-support with uninterrupted coverage under the York plan prior to disability. Please contact Sun Life for more information about coverage for a disabled dependent.

- Copy of birth certificate, baptismal certificate or mail with the same address as employee

Group Life Insurance (Not all benefit plans may apply to you.)

Beneficiary(ies) Name(s) in Full (Last name, First name)	Date of Birth* **(mm/dd/yyyy)**	Relationship	% Share
If you do not appoint a beneficiary your estate becomes your beneficiary.			100%

Voluntary Accidental Death & Dismemberment (VADD) Insurance (Not all benefit plans may apply to you.)

Benefit Amount Selected: $_____ (coverage begins at $20,000 to a maximum of $500,000 in $10,000 increments) Monthly cost sheet is found in yu link under Forms and Documents/VADD Premium Chart. The link is https://yulink-new.yorku.ca/group/yulink/forms-and-documents

Make your VADD selection here: Single ☐ Family ☐ **

****If you elect family coverage it is your responsibility to advise us when to change your coverage to single, such as when you no longer have dependents covered under your benefits.

Beneficiary(ies) Name(s) in Full (Last name, First name)	Date of Birth* **(mm/dd/yyyy)**	Relationship	% Share
If you do not appoint a beneficiary your estate becomes your beneficiary.			100%

*If beneficiary under the age of 18 complete the section below.

If you have designated a minor child(ren), a trustee must be designated. Any payments becoming due while the beneficiary(ies) is/are minor are to be made payable to the trustee, or failing such trustee to the duly appointed guardian of such minor child as trustee. Payment to the trustee will discharge Sun Life Assurance Company of Canada. I appoint the following individual as trustee:

Name: _____ **Relationship**:_____ **Contact number**:_____

Group Life and/or VADD Contingent Beneficiaries

If there are no surviving beneficiaries at the time of my death, I declare that the following contingent beneficiaries shall receive the proceeds. If there are no surviving contingent beneficiaries at the time of my death, the proceeds shall be paid to my estate. Unless I specify otherwise, my contingent beneficiaries will apply to all my benefits.

Contingent Beneficiary(ies) Name(s) in Full (Last name, First name)	Date of Birth*	Relationship	% Share
			100%

I hereby revoke any prior beneficiary designation made for the purposes of the Group Insurance Plan and VADD Insurance, if applicable, and appoint the person(s) named above as my designated beneficiary to receive any death benefits that may be payable to a beneficiary in accordance with the terms of the Plan(s). I reserve the right to change this designation, subject to the provisions of any law or regulation, which may apply. However, I understand that the above beneficiary designation(s) shall remain legally valid and shall continue to be effective in the event of my death, unless and until such time as I inform the University of any change by executing a new beneficiary designation form. If my designated beneficiary predeceases me and no other beneficiary has been designated to replace the designated beneficiary that predeceased me, and proceeds that would have been payable to such beneficiary will be paid to my estate.

By signing this form or by providing my personal information to the University, I agree the information is complete and accurate to the best of my knowledge. I am authorized to release information concerning my spouse and my dependents, for the purpose of determining eligibility for benefits. I certify that I am authorized by my spouse and/or dependents to disclose and receive information about them that is used for these purposes. I understand it is my responsibility to notify the University of any change. The insurer reserves the right to obtain reimbursement from me for any benefits paid due to error, misrepresentation or lack of notification. I consent to the premium deductions if any from my pay, according to the provisions of the plan.

_____ _____

Employee Signature **Date**

Pension & Benefits, University Services Centre, 4747 Keele Street, Toronto ON M3J 2N9
Telephone 416-736-5853. You may e-mail the completed form to askpb@yorku.ca