APPLICATION FOR EXTENDED HEALTH CARE, DENTAL, AND PRESTIGE TRAVEL/TRIP CANCELLATION PLANS

If you have any questions about the Plan, or need assistance completing your application form, please contact the Plan Administrator, Johnson Inc., at 1.877.989.2600 (Option #2) or via email at pbservicewest@johnson.ca.

1. APPLICATION INFORMATION – PLEASE PRINT CLEARLY

First Name(s)	**Last Name**		**Gender** ☐ **Male** ☐ **Female**
Address (including Apartment/Unit Number)			**Telephone Number** ( )
City/Town	**Province/Territory**	**Postal Code**	**Email Address**
BCRTA Membership Number		**BCRTA Membership Number (Spouse)**	
Date of Birth (Day/Month/Year) DAY / MONTH / YEAR	**Provincial Health Number**		**Fair Pharmacare Registration Number**

2. PLAN INFORMATION

EXTENDED HEALTH CARE (EHC) PLAN:

I wish to enrol in the EHC Plan: ☐ Yes ☐ No

Indicate status of coverage required: ☐ Single ☐ Couple ☐ Family

Are you enrolled in your Province's Pharmacare Plan*? (Applicable to Provinces/Territories where a Pharmacare Program exists.)

☐ Yes ☐ No

***If no, please contact your Province's Pharmacare to enroll in their program as it is a requirement for the BCRTA Plan.**

Prescription Drug Option (select one)

Plan 1 – If either you or your spouse was born in 1939 or earlier:

☐ Drug Option A: $1,200 per household ☐ Drug Option B*: $2,500 per household

Plan 2 – If you and your spouse were born in 1940 or later:

☐ Drug Option A: $1,500 per household ☐ Drug Option B*: $3,500 per household

*Note: Once you enrol in Drug Option B, you much remain in the Plan for 24 months.

PRESTIGE TRAVEL PLAN (only available with EHC):

I wish to enroll in the Travel Plan: ☐ Yes ☐ No *NOTE: You must enrol in the EHC Plan to elect Travel Plan coverage.*

DENTAL PLAN:

I wish to enrol in the Dental Plan (80% Basic, 80% Minor, 50% Major): ☐ Yes ☐ No

Indicate status of coverage required: ☐ Single ☐ Couple ☐ Family

Check here if you are maintaining coverage in addition to this Plan: ☐

Are you the: ☐ Member OR ☐ Spouse

NOTE: Coverage for this Plan will become effective the 1st day of the month following the date of receipt of this form.

Insurance Company _____ **Policy Number** _____

If you are not maintaining additional coverage, when transferring from an employer sponsored group insurance plan or your spouse's employer sponsored group insurance plan, you must provide the termination date (in space below). Coverage for this Plan is effective the day after your or your spouse's plan terminates.

Termination Date of Your or Your Spouse's group benefits plan:	DAY	MONTH	YEAR

NOTE: Those with current group benefits coverage may apply within 60 days of losing existing employer coverage. After 60 days of prior plan termination, evidence of insurability is required.

IMPORTANT – YOU MUST COMPLETE AND SIGN SECTION 4 ON THE REVERSE FOR COVERAGE TO BE IN FORCE

If you have selected Couple or Family Coverage, please provide Spousal/Dependent Details below:

First Name(s)	Last Name			Gender ☐ Male ☐ Female
Provincial Health Number	Date of Birth			Dependents age 21+
	DAY	MONTH	YEAR	☐ Full Time Student ☐ Disabled
First Name(s)	Last Name			Gender ☐ Male ☐ Female
Provincial Health Number	Date of Birth			Dependents age 21+
	DAY	MONTH	YEAR	☐ Full Time Student ☐ Disabled
For additional Dependents, please provide information on a separate page.				

3. MONTHLY PREMIUM PAYMENT

☐ **Automatic Bank Withdrawal.** I have enclosed a **sample cheque marked "VOID"**. I authorize Johnson Inc., the Plan Administrator, to make monthly deductions (including mid-term adjustments and arrears) from the bank, trust company or credit union account shown on the cheque. Deductions are withdrawn one month in advance, for example, the August 5th deduction pays for September coverage.

4. CONSENT AND SIGNATURE

I hereby certify that I am a Member in good standing with the British Columbia Retired Teachers' Association and my eligibility ceases upon termination of my BCRTA membership.

I authorize that my premium for this insurance, including any mid policy year adjustments, arrears and renewals, be deducted in monthly amounts due on or after this date of application. I understand that my policy will be automatically cancelled should Johnson Inc. receive two or more Non-Sufficient Funds (NSF) notices on my account.

I recognize that the BCRTA Extended Health Care Plan requires members to be enrolled in their provincial Pharmacare Program. If you are not already enrolled in your province's Pharmacare Program, please contact Pharmacare as soon as possible.

I understand that EHC and Dental coverage will begin on the day after my current group benefits terminate OR, if maintaining coverage under my current group plan, on the 1st of the month following the date of receipt of application. If applying as a late applicant, I understand EHC coverage will become effective the date the completed application is approved by the Insurer.

I also understand that unless I advise Johnson Inc. in writing to the contrary, the coverage I have selected **will remain in effect for each policy year thereafter.** Johnson Inc. will provide me with notification of my renewal before the beginning of each subsequent policy year, which is September 1st.

I authorize my "Group", the British Columbia Retired Teachers' Association, my "Plan Administrator" Johnson Inc., and my "Insurers" Desjardins Financial Security and Royal & Sun Alliance Insurance Company of Canada, and my "Administrator" Global Excel Management Inc. (collectively, the "Providers") to collect, use, maintain and disclose my financial, medical and other personal information, including the information relating to any spouse or dependent who may be the subject of this application, (the "Information") for the purposes of the Extended Health Care with Prestige Travel Plan and/or Dental Plans (the "Plans") administration and audit and the assessment, investigation, management, processing and/or underwriting of this application and any claims under the Plans (collectively, the "Purposes"). **I authorize** any person with Information, including any medical and health professional, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer investigative agency and any administrators of other benefits programs to collect, use, maintain and exchange this Information with each other and with the Providers and any replacement Plan Administrator, Insurer, Administrator approved by my Group, for the Purposes. **I understand** that any coverage will not become effective until approved by the Providers. **I authorize** the use of my Provincial Health Number and any Group Member ID for the purposes of identification and administration.

Signature of Applicant _____ **Date** _____

Signature of Spouse (if Couple or Family coverage selected) _____ **Date** _____

PLEASE FORWARD YOUR APPLICATION TO:

JOHNSON INC.
GROUP BENEFITS SERVICE
#110 – 9440 202 Street
Walnut Grove Commerce Centre
Langley BC V1M 4A6

Please direct all inquiries about the application, policies, authorization for premium deductions or any written notice of change or cancellation to the Plan Administrator, Johnson Inc. at 1-877-989-2600 (Option #2) or pbservicewest@johnson.ca.