Catholic Independent Schools of Vancouver Archdiocese

Retiree Benefit Plan Programme

RETIREE ENROLLMENT FORM for 2018-2019

Please select (☑):

○ **New Applicant** ○ **Re-enrolment** ○ **Cancel Coverage**

Effective Date: _____

What you need to:

Know:

- that available retiree benefits are for Extended Health and/or Dental benefits only
- that coverage may be for a variation of single, couple or family coverage for Extended health and/or Dental benefits
- that the retiree booklet that describes your benefit coverage (Benefit Class 5) can be found online at www.cisva.bc.ca
- that inquiries regarding benefit eligibility should be directed to GWL at 1-800-957-9777
- that there is an administration fee of $3.00 per month ($30.00/yr) to participate in the retiree program
- *every insufficient funds (NSF) will incur **$30.00** fee*

Report:

- any changes to your status, etc., that may have a direct impact on your premiums (ie: an increase or decrease to your number of dependents)
- any new/changed/alternative contact information. Example: you may live out-of-province/country for part of the year. If so, please report your alternate contact information on the back of this form.

Submit:

- premiums by the appointed deadline. As with all insurance policies, arrears of premium contributions may lead to termination of your policy. It is your responsibility to ensure that your account is always paid up-to-date.

Rates for the **2018-2019** policy year (10 month premiums/ 12 months coverage):

Dental:	**Single: $ 72.84**	**Couple: $ 145.68**	**Family: $ 185.34**
Extended Health:	**Single: $ 66.64**	**Couple: $ 130.52**	**Family: $ 192.34**
Administration Fee:	**+$ 3.00**	**+$ 3.00**	**+$ 3.00**

Please select (☑)coverage:

Dental:	Single☐	Couple☐	Family ☐
Ext. Health:	Single☐	Couple☐	Family ☐

For BENEFITS OFFICE Use Only: Payment Option

Pre-Authorized Debit Information

Premium Amount: _____

Date(s) of deduction: _____

Deduction Frequency: _____

Monthly ☐ Quarterly ☐ Semi-Annual☐ Annual ☐

Send your Pre-authorized Debit Form to our office. **Premiums will be deducted on your account on the 1st day of the month.** Please sign below and return to the Benefit Administration Office.

(Please print clearly) **Member Identification Number:** _____

NAME: _____ **PHONE:** _____

ADDRESS: _____

CITY: _____ **POSTAL CODE:** _____

EMAIL ADDRESS: _____

SIGNATURE: _____ **DATE:** _____