PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

TTOC APPLICATION FOR EXTENDED HEALTH CARE BENEFITS

OFFICE USE ONLY

Policy number	Division	Sub-division	Class	Effective date (mm-dd-yyyy)
79626	1		1	

PART 1 — APPLICANT INFORMATION

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

Street address	City	Province	Postal code
Mailing address (if different from above)	**City**	**Province**	**Postal code**

Email address	Daytime phone number (10 digits)

Have you previously had coverage under a School District Plan as a Teacher or TTOC? ☐ Yes ☐ No	If yes, policy number 200___ ___	Member ID

PART 2 — EXTENDED HEALTH CARE: Rates are subject to change

☐ **I am applying for Extended Health Benefits**

- Monthly Rates effective July 1, 2023: ☐ Single $197.77 ☐ Couple $361.91 ☐ Family $439.04

PART 3 — DEPENDENT INFORMATION: Check Extended Health Care box for each dependent if applying for coverage

FIRST NAME	LAST NAME	MIDDLE INITIAL	BIRTHDATE	GENDER	NAME OF SCHOOL OR DETAILS OF DISABILITY*	EXTENDED HEALTH CARE
Spouse			(mm-dd-yyyy)	☐ M ☐ F		☐
First child			(mm-dd-yyyy)	☐ M ☐ F		☐
Second child			(mm-dd-yyyy)	☐ M ☐ F		☐
Third child			(mm-dd-yyyy)	☐ M ☐ F		☐

*Complete this section if child is over age 19 and attending school full-time, or is disabled. If you have additional dependents, list them in *Part 6 — Additional Information* on page 2.

PART 4 — ACCOUNT HOLDER(S) INFORMATION (Policy sponsor, if different from member)

Last name	First name
Last name	**First name**

Business name (if applicable)

Street address	City	Province	Postal code	Daytime phone number (10 digits)

PART 5 — PAYMENT METHOD (Choose one method below)

☐ **Pre-authorized debit (PAD)** — Attach a cheque marked VOID or a pre-authorized payment form provided by your bank that identifies your branch and account information. This will only apply to the payment being withdrawn from your banking account (PAD). If you wish to change your banking information to receive claims payments in that same account, please contact us. The only frequency available for PAD is monthly. Pre-authorized payment account type: ☐ Business ☐ Personal.

☐ **Credit card** ☐ VISA ☐ MasterCard ☐ American Express

Name on credit card	Last 4 digits of credit card	Expiry date (mm-yyyy)

Once we receive your authorization form, we will contact you to obtain the credit card number.

PART 6 — AUTHORIZATION

I (We) authorize PBC to make deductions, from the credit card or bank account indicated, either through monthly regular recurring payments and/or one-time payments from time to time, for payment of all charges arising under the Member's policy. Each debit will occur on or about the first business day of the month, beginning on the effective date of coverage.

I (We) agree to waive the requirement for PBC to notify me (us) of this authorization before the first payment is processed and any subsequent monthly regular payment.

The withdrawal amount is considered variable under the Payments Canada rules.

PBC will provide me (us) at least three (3) business days written notice should there be a change in either the amount of the monthly regular payment or premium due date. Any notices, to be sent under this agreement, will be sent to the Member's most recent address that PBC has on record at the time a notice is sent.

All persons, whose signatures are required to sign on this account, have signed this authorization.

Pacific Blue Cross may terminate coverage, or change the method of payment with written approval of the Policy Sponsor to another qualifying method, should a withdrawal be refused for any reason.

Pacific Blue Cross will charge a fee for any withdrawal that is not honoured.

I (We) will notify PBC in writing of any changes in the account information or termination of this authorization within ten (10) business days prior to the next debit.

I/We have certain rights if any debit does not comply with this agreement. To obtain more information on my/our recourse rights, I/we may contact my/our financial institution or visit payments.ca.

Account/card holder's signature	Date (mm-dd-yyyy)	Second account/card holder's signature (if required)	Date (mm-dd-yyyy)
X		X	

PART 7 — APPLICANT SIGNATURE

I agree to the conditions of the contract between my plan sponsor and Pacific Blue Cross (PBC). I confirm that the information I have provided is true and complete.

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 PBC up to the amount advanced to me pending such settlement or judgement.

I understand and consent that some of the personal information provided by me and my dependents under this group plan may be disclosed to agents and representatives of PBC and other providers/insurers and their agents and representatives for the purposes of assessing and providing benefits coverage. I also understand and consent to the disclosure of this personal information to my plan sponsor when required or permitted by contract between PBC and my plan sponsor; and to the retention, use and disclosure of this personal information in accordance with PBC Privacy Policy. The privacy policy is available online at pac.bluecross.ca or by calling Pacific Blue Cross at 604 419-2000.

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

PART 8 — EMPLOYER/PLAN ADMINISTRATOR

Name of company/organization	Employee ID number	School district number	Eligible date (mm-dd-yyyy)

☐ Please check box if this employee is an eligible TTOC with your School District

Employer/Plan administrator's signature	Date (mm-dd-yyyy)
X	

PART 9 — OTHER COVERAGE

Complete this section if you previously waived coverage for yourself and/or any of your dependents and are applying after the 90 day enrollment period:

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

PART 10 — ADDITIONAL INFORMATION

WHAT YOU NEED TO KNOW

ELIGIBILITY

- This plan is only available to Teachers Teaching on Call. Individuals covered under the plan must be covered under a provincial medical plan.
- You must enroll in this plan for a minimum of 12 months unless you obtain group coverage through another plan.
- If you are transferring between the District plan and the Teachers on Call plan, please note that your claims history will follow you between plans. If you are charged the deductible twice in error, please contact our call center to request an adjustment.

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 permitted under your plan if certain criteria are met.
- Enrolment effective date is always 1st of the month. Terminations on the plan are at the end of the month.

WAIVING GROUP BENEFITS

- If another plan covers you/your dependent(s) for Extended Health Care benefits, you may waive such benefits under this plan.
- If you waive coverage, you may enroll yourself, your spouse and/or dependents at a later date only if you provide proof of continuous coverage since the termination of your coverage. You must provide the same proof for your spouse and/or dependents if you wish to enroll them. You must apply to enroll yourself, your spouse and/or dependents within 90 days of the termination of your other continuous coverage.
- **Failure to return this application will be treated as if you waived coverage.**
- You must complete *Part 1 — Applicant Information* and *Part 3 — Dependent Information* (if applicable) even if you or your spouse and/or dependents are waiving coverage.

TIPS FOR COMPLETING THIS APPLICATION

1. Check to ensure all sections of the form have been completed.
2. If all of the requested information is not provided, this form will be returned to you for completion.

INCOMPLETE INFORMATION MAY DELAY THE PROCESSING OF YOUR APPLICATION.

PACIFIC BLUE CROSS®

MAIL YOUR APPLICATION

Pacific Blue Cross
PO Box 7000, Vancouver, BC V6B 4E1

DROP IT OFF

4250 Canada Way
Burnaby, BC V5G 4W6

FAX IT

604 419-2199

EMAIL IT

inhealth@pac.bluecross.ca