CITY OF SURREY
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City of Surrey
Benefits Plan Form

CUPE 402

☐ **INITIAL APPLICATION**
☐ **CHANGE**

MPLOYEE INFORMATION					
Last Name		First Name			Middle Initial
Employee Number		**Marital Status**			**Gender**
Social Insurance Number		☐ Married	☐ Common Law	☐ Single	M ☐ F ☐
Address	City	Postal Code			
Date of Birth (dd-mmm-yyyy)	Date of Hire (dd-mm-yyyy)	Phone Number			

DEPENDENT INFORMATION (Children under 21 years of age or age 21 and above Student in full-time attendance at a post secondary institution.)			
Dependents Names (Last Name, First Name, Initials) **Add** ☐ **Delete** ☐	Gender (M/F)	Date of Birth (dd-mmm-yyyy)	Student/Disabled - (Information required)
Spouse	N/A		**N/A**
Child	N/A		**S** ☐ **D** ☐
Child	N/A		**S** ☐ **D** ☐
Child	N/A		**S** ☐ **D** ☐
Child	N/A		**S** ☐ **D** ☐

PHARMACARE REGISTRATION NUMBER: _____
(Pharmacare Phone Number: 604-683-7151 or 1-800-663-7100)

Provincial Medical (MSP)	Extended Health Care (EHC)	Dental Care
Personal Health Care # _____	*Single* ☐ *Family* ☐ *No Coordination of Benefits* ☐ Spouse's Carrier _____ Spouse's Group No. _____	*Single* ☐ *Couple* ☐ *Family* ☐ *No Coordination of Benefits* ☐ Spouse's Carrier _____ Spouse's Group No. _____

I understand that for our Manulife coverage of Extended Health and Dental if I do not enroll my spouse/dependents when first able, any future application is limited to life changes. Examples: divorce of my spouse, new spouse, death of my spouse or a change to my spouse/dependents benefit coverage.

_____

BASIC LIFE AND BASIC AD&D BENEFICIARY DESIGNATION(S) - If you are designating more than one beneficiary, please indicate the % of the benefit for each beneficiary. A trustee should be appointed if you are naming a person under age 19. Please obtain a copy of the "Declaration Appointing Trustee" form from Human Resources.

Beneficiaries Names (Last, First, Middle Initial)	%	Relationship

_____ _____
Employee Signature Date Signed

I hereby declare that the information on this application, to the best of my knowledge and belief, is complete and true and authorize my employer to make the necessary payroll deductions, if any, for my contributions. I understand the use of my Social Insurance Number is for identification purposes and hereby authorize its use for this purpose. _____ _____
Employee Signature Date Signed

City of Surrey

DECLARATION FOR QUALIFICATION OF PARTNER

I, _____, hereby elect _____
to qualify as my Common-Law Spouse.

Date of cohabitation _____.

The term "Common-Law Spouse" means a person who resides with the employee in a common-law relationship for a period of at least one year. **Documentation for proof of residency is required and must be submitted along with this declaration**.

I warrant that the reasons given above to substantiate the qualification of my Spouse are accurate and I understand that the strict accuracy of this information is a condition of the exercise of this right of qualification by me. I further understand that no payment will be made under a benefit provision in respect of the above person, if, on the date of a claim, he or she could not at that time be qualified as a Spouse.

Effective benefit entitlement will be subject to receipt of this signed form together with supporting documentation.

Dated at _____ this _____ day of _____ in the year _____.

_____
(Signature of Insured)

_____
(Printed Name of Insured)