

Application for Parental Leave Program Benefit

please email completed forms to benefits@doctorsofbc.ca

Physician Information

| | |
|-----------------------------|---------------------|
| Doctors of BC ID, if known: | MSP Billing Number: |
| Full Name: | Email: |
| Home Address: | Telephone: |
| | Home Cell |

Parental Leave Information

Actual/Expected Last Day at Work (mm/dd/yyyy):
(Must not be earlier than 12 weeks prior to due date or placement)

Actual/Expected Child's Date of Birth or Placement (mm/dd/yyyy):

Total Months of Leave, if known (including any additional months being taken outside of the program). This is for your membership dues reduction:

Is your spouse/partner a physician? Yes No If yes, please provide details below:

Name of Spouse/Partner: MSP Billing Number, if known:

Income Information

Your benefit will be based on eligible income paid to you in the calendar year prior to your leave. Income for the twelve months prior to the birth or placement of your child may be used if you have no or minimal income in the prior calendar year. You are not required to provide income information as we request it from the appropriate sources.

Submit Later – The following information will be needed as soon as available to prevent delay of benefit payments:

1. Email Confirmation of your last day at work (if not already on leave when submitting application)
2. Birth Certificate or letter from attending physician/midwife
3. Declaration of weekly earnings (on the Doctors of BC website once claim setup is confirmed)
4. Further information if required for audit purposes, on request

Certification

I hereby certify that the information provided on and with this application is true and accurate and that I have not made and will not make a claim from any other maternity, pregnancy or parental leave program for the benefit period I am claiming under the Parental Leave Program (PLP). I understand and agree that if I work for more than 15 hours in a week I am not eligible to claim a benefit for that week.

I hereby certify that the information provided in this application and all attachments is true and accurate and that I will abide by the terms of the PLP. I authorize the use of information in this application package for the administration of the PLP.

Signature of Applicant: _____ Date (mm/dd/yyyy): _____

Parental Leave Program Consent and Declaration Form

To: The Ministry of Health (MOH)

And To: The British Columbia Medical Association (BCMA) operating
as Doctors of BC

1. I give consent and make this declaration in connection with my application for benefits under the Parental Leave Program (PLP).
2. I hereby declare that:
 - a. I am a physician registered with the College of Physicians and Surgeons of British Columbia, and
 - b. I practice medicine in British Columbia.
3. I understand that, in order for the Doctors of BC to administer the PLP and for the MOH to monitor the administration of the PLP, both the Doctors of BC and the MOH must know all amounts earned by me during the calendar year or in the twelve months prior to my leave and while I am receiving benefits under the PLP:
 - a. from MSP (fee-for-service income)
 - b. from MOH (sessional income)
 - c. from a non-salaried Service Contract
4. To give effect to paragraphs 3 and 4 above,
 - a. I hereby authorize the MOH to disclose to the Doctors of BC the total amount of payments for services rendered by me during the calendar year or in the twelve months prior to my leave, all amounts paid to me while I am receiving benefits under the PLP.
 - b. I hereby authorize the Health Authority/Agencies to which I rendered services during the calendar year or in the twelve months prior to my leave to disclose to the Doctors of BC the total amount paid to me under the Sessional and/or Service Contract Agreement(s) during this period.
 - c. I hereby authorize the Doctors of BC to disclose to the MOH, and the MOH to collect from the Doctors of BC, all information in their possession relating to my benefits under the PLP, any information relating to my medical professional income during the calendar year or in the twelve months prior to my leave and while I am receiving benefits under the PLP; for the purposes of the administration or the monitoring of the PLP, including the recovery of any amounts under paragraph 5.
5. I understand that if I receive a maternity, pregnancy or parental leave benefit from another provincial program in any week while receiving benefits under the PLP, I will not be eligible to receive a benefit for that week.

Name of Applicant (please print): _____

Signature of Applicant: _____

Date (mm/dd/yyyy): _____

The personal information on this form is collected only for the purposes of administration of the PLP.

Parental Leave Program Direct Deposit Form

Doctors of BC PLP benefit payments will be deposited directly into your bank account on a bi-weekly basis following online declaration. Please link your banking to PLP Benefit Payments on our website [here](#)

Alternatively, you can provide a copy of a void cheque for the bank account into which your benefit payments are to be deposited. If the payments are to be issued to your corporation, please include a copy of your certificate of incorporation if it has not been previously provided.

First and Last Name:

E-mail Address:

(for deposit confirmation)

Account Type:

Corporate

Personal

I hereby authorize the Doctors of BC to deposit my DOCTORS OF BC PLP benefit payments directly to my bank account. I have linked the appropriate bank account online or have attached a copy of a void cheque for the account to be used for this purpose.

Signature:

Date (mm/dd/yyyy):

Please email all completed forms to benefits@doctorsofbc.ca

Please note that Doctors of BC PLP benefit payments will not be made without receipt of this information.

If you have any questions regarding this procedure, please contact the Parental Leave Program Administrator:

T 604.638.2969

benefits@doctorsofbc.ca