03/21

Health Benefits Trust Fund (HBTF) Plan

MOA Enrollment Form

- Print clearly, in black or blue ink, and complete both pages of this form. **Incomplete forms will be returned.**
- Sign and date the form on the reverse and forward it to Doctors of BC at the address below.
- The applicant (and dependents) must be covered under a Provincial Health Care Plan (ie BC MSP) to be eligible to participate in this plan.
- Retain a photocopy for your files. **IMPORTANT**: The original Enrollment Form will be required in the event of a Life Insurance claim.

At Doctors of BC, we know that confidentiality of personal information is important. Go to https://www.doctorsofbc.ca/privacy-policy to view Doctors of BC's Privacy Policy. By participating in this Plan, you authorize Doctors of BC and its insurers to use the information collected on this form for benefits administration.

1. Personal Information

All applicants must be under age 65 at the time of application.
Plan details and changes will be sent to you via your provided Preferred Email Address.

Last Name | First Name | Middle Initial

Date of Birth (mm dd yyyy)

Date of Employment (or date working 20 hours per week) (mm dd yyyy)

Occupation

Preferred Email Address

Gender: ☐ Male ☐ Female

2. Group Life / AD&D

Crossed off beneficiary designations must be initialed or request a Change of Beneficiary form from the HBTF Plan Administrator. Physicians are NOT eligible for this benefit.

Select the Group Life/AD&D benefit you wish to apply for **(select one)**:

☐ **$20,000** ☐ **$50,000**

Designated Beneficiary(ies) – In the event of my death, I name the person(s) below to receive the policy proceeds. To the extent permitted by Law, I reserve the right to change the beneficiary(ies) named below:

Last Name	First Name	Relationship to You	Percentage

If designating a beneficiary who is a minor or who lacks legal capacity please appoint a Trustee below. Before designating a Trustee, you should seek legal advice:

Full Name of Trustee | Relationship to You

3. Long Term Disability

Select the monthly benefit amount you wish to apply for. *(**Please Note:** Coverage greater than $1,000 will require the employee to complete an Evidence of Insurability form and be approval by the carrier before coverage will be effective.)*

Taxable monthly benefit: (check one only)

☐ $ 1,000 ☐ $ 1,200 ☐ $ 1,500
☐ $ 2,000 ☐ $ 2,500

The amount selected should not exceed **85%** of gross monthly earnings.

***Gross Monthly Earnings**

$

4. Extended Health/ Dental Dependent Information

☐ Check if applying for single coverage only (no dependents).

If you wish to refuse this coverage, complete Section 5 on reverse.

An "eligible dependent" is defined as any person who is:

- Your legal spouse, or a person with whom you have lived for one year and have publicly represented as your spouse.
- Your unmarried dependent child(ren) under age 22, or under age 25 if a full-time student attending an educational institution recognized by the Canada Revenue Agency (CRA) and entirely dependent on you for financial support.

If applying for dependent coverage, complete the section below (attach a separate sheet if necessary).
Dependent(s) not listed will be subject to proof of good health if application is made at a later date.

First Name	Initial	Last Name	Gender	Relationship (spouse/son/daughter)	Date of Birth (mm dd yyyy)
Spouse			☐ Male ☐ Female		
Child			☐ Male ☐ Female		
Child			☐ Male ☐ Female		
Child			☐ Male ☐ Female		

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Vancouver BC V6J 5A4
doctorsofbc.ca

4a. Dependent Students

If any of the dependent children listed in section 4 are full-time students age 22 or over but under the age of 25, and entirely dependent on you for financial support; please indicate below the name of the student and the educational insitution recognized by the CRA being attended in the spaces provided.

First Name	Name of educational institution recognized by the CRA

5. Refusal of Benefits

Complete this section if you wish to refuse Extended Health Care and Dental Care for yourself and/or your dependent(s). **This will be allowed only if similar benefits are currently in force under your spouse's group policy.**

If you wish to add this coverage at a later date, satisfactory proof of good health for you and/or your dependent(s) may be required.

I refuse Extended Health and Dental coverage as I and/or my dependents are insured under my spouse's group policy.

For (check one only):

- ☐ Myself and my dependent(s) (if any)
- ☐ My dependent(s) ONLY

Current Insurer	Policy Number	Effective Date of Coverage (mm dd yyyy)

I understand that if my and/or my dependent(s)' coverage terminates under the policy indicated above, I can apply for coverage under this Plan within 90 days of loss of such coverage without proof of good health. If you do not make application within 90 days, you and/or your eligible dependents will be required to provide proof of insurability acceptable to carrier to be covered.

6. Applicant Signature

(Must be completed by ALL Applicants)

I am authorized to disclose information about my spouse and dependents in order to enroll them in the plan.

By enrolling in this Plan, I authorize the following:

Canada Life Assurance Company ("Canada Life"), its agents and service providers its re-insurers and their service providers to collect, use and disclose relevant information about me to underwrite, administer and adjudicate claims, my plan sponsor and its agents and Doctors of BC to use the information collected in this form for benefits administration and to make any necessary payroll deductions which may be required; Canada Life, its agents and service providers and my plan sponsor and its agents to collect, use and disclose information about me, my spouse and dependents necessary for enrollment and purposes of continuing administration of the plan.

I declare that the information above is accurate and true.

Applicant's Signature	Date (mm dd yyyy)

7. To be completed by Physician/Employer

(Must be completed by the sponsoring Member)

If you are a self-employed physician, you may name yourself or your Corporation as Employer)

Name of Physician or Employer:	HBTF Business ID

Address:

City	Province	Postal Code

Telephone Number:	Area Code	Number	Fax Number:	Area Code	Number

I confirm that the Medical Office Staff Applicant is actively working in the office 20 hours or more per week.

I understand that if the Applicant is not actively working on the date coverage would normally become effective, it is my responsibility to notify the HBTF Plan Administrator as coverage will not become effective until the Applicant returns to active work.

Physician Member's Signature	Date (mm dd yyyy)

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