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Health Benefits Trust Fund (HBTF) Plan

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.

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

(Must be completed by ALL Applicants)

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.

Date of Employment and Earnings are not required for physicians applying for coverage.

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

Gross Monthly Earnings (Office staff employees only): $

Preferred Email Address

Gender: ☐ Male ☐ Female

2. Group Life / AD & D

Must be completed by Medical office staff only.

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: ☐ $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

Must be completed by Medical office staff only.

Physicians are NOT eligible for this benefit.

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.

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	Relationship (spouse/son/daughter)	Date of Birth (mm dd yyyy)
Spouse				
Child				
Child				
Child				

If any of the above dependent children 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 institution recognized by the CRA being attended in the spaces provided.

First Name	Name of educational institution recognized by the CRA

T 604 638 2908
F 604 638 2909
TF 1 800 665 2262

115—1665 West Broadway
Vancouver BC V6J 5A4

doctorsofbc.ca

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 31 days of loss of such coverage without proof of good health. If you do not make application within 31 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:

Great-West Life Assurance Company ("Great-West Life"), its agents and service providers its reinsurers 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; Great-West 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 enrolment and purposes of continuing administration of the plan.

I declare that the information above is accurate and true.

Applicant's Signature	mm dd yyyy

7. To be completed by 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 Employer:	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	mm dd yyyy

TO BE COMPLETED BY DOCTORS OF BC STAFF – DO NOT WRITE IN THIS AREA

Business ID: _____ **Member ID:** _____

Effective Date: _____ **Statement of Coverage:** _____

_____

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