



OPTIONAL EMPLOYEE PLAN COVERAGE

EXTENDED HEALTH CARE AND VISION PLAN

If your Employer participates in this plan, you have the option to participate. You have **30 days** from your effective date to select your level of coverage. Health evidence will be required for all late applicants. If you participate in the Extended Health Care & Vision Plan, **you must participate at least one year**, you cannot reduce or remove coverage until the first anniversary of coverage effective date.

Absence of checkmark below will automatically be considered a waiver of Extended Health Care and Vision coverage.

Please select your coverage: Employee Only Family (Including Spouse and/or Children)
 Spouse Only No Coverage

DENTAL SERVICES PLAN

If your Employer participates in this plan, you have the option to participate. You have **30 days** from your effective date to select your level of coverage. Late applicants will have reduced benefits for the first 12 months of coverage. If you participate in the Dental Services Plan, **you must participate at least one year**, you cannot reduce or remove coverage until the first anniversary of coverage effective date.

Absence of checkmark below will automatically be considered a waiver of Dental coverage.

Please select your coverage: Employee Only Family (Including Spouse and/or Children)
 Spouse Only No Coverage

COORDINATION OF BENEFITS

Complete this section if you, your spouse or dependent child(ren) are covered by any other plan for Extended Health, Vision, and/or Dental Care. NEBS Plan coverage will be coordinated with other plans so that your benefits do not exceed 100% of actual allowable expenses.

Person with plan coverage: _____ Last Name, First Name

Employer Name: _____ Insurance Company: _____

Benefits covered by plan: Vision Care Extended Health Care
 Dental Care Prescription Drugs

OPTIONAL LIFE INSURANCE

Employees may apply to purchase additional life insurance coverage for themselves and/or their spouse. An application will be mailed to you.

Optional Life Insurance is available in units of \$10,000 coverage to a maximum of 20 units (\$200,000). The Employee is 100% responsible for the premium costs. Coverage for optional insurance shall not be effective until the first day of the month following the date that the application is approved.

I am interested in finding out more about Optional Life Insurance for myself.
 I am interested in finding out more about Optional Life Insurance for my spouse.



DEPENDENT PARENT INSURANCE

Employees may apply to purchase life insurance coverage for a dependent parent who resides with them and is under 70 years of age. An application will be mailed to you.

Dependent Parent Insurance is available for your dependent parent(s) who are under 70 years of age, living with you and are financially dependent on you. A flat amount of \$5,000 insurance is available to qualified dependents.

The Employee is 100% responsible for the premium costs. Coverage for optional insurance shall not be effective until the first day of the month following the date that the application is approved.

A copy of the birth certificate must be provided when submitting the dependent parent optional life insurance application.

I am interested in finding out more about Dependent Parent Insurance for my Father/Father-in-Law.
 Date of Birth: dd / mm / yyyy

I am interested in finding out more about Dependent Parent Insurance for my Mother/Mother-in-Law.
 Date of Birth: dd / mm / yyyy

INSURANCE AND HEALTH BENEFITS PLAN BENEFICIARY INFORMATION

Your insurance plan will provide benefits to those you name below in the case of your death. If you do not name a beneficiary, death benefits will be paid to your estate. If more space is required, please copy this page.

I hereby name my beneficiary(ies) for Life Insurance and Accidental Death, Disease, and Dismemberment Insurance as follows in **equal shares unless otherwise provided below:**

Beneficiary Name (Last Name, First Name)	Relationship to Employee	% Allocated
Total Allocation Must Equal 100%		

THIS SECTION IS TO BE COMPLETED BY THE EMPLOYER

Please print clearly in BLUE INK

EMPLOYER INFORMATION

Employer Name: _____
 Contact Person: _____ Last Name, First Name _____ Email: _____

EMPLOYEE INFORMATION

Employee Name: _____ Last Name, First Name _____ Hire Date: _____ dd / mm / yyyy
 Position Title: _____ Annual Salary: _____

Salary shall mean the Employee's regular annual salary paid by the Employer, not including bonuses, overtime earnings, subsistence allowance, housing allowance, living allowance, or any other monies paid in addition to the Employee's ordinary wages.

Please select one:

Permanent Full Time Permanent Part Time(1) Part Time Ratio(2): _____
 Term(3) Term Start Date: _____ dd / mm / yyyy Term End Date: _____ dd / mm / yyyy

- (1) Permanent part-time Employees must work a minimum of 20 hours per week to be eligible for health benefits. Permanent part-time Employees must earn 35% of the YMPE for 24 months to be eligible for Pension.
- (2) Part time ratio is a percentage of the full-time rate. Example: 35 of 40 hours per week or 0.875
- (3) Term employees are eligible if employment conditions meet the same general criteria as permanent full-time or permanent part-time Employees. For insurance and health benefits and pension plan eligibility, employment must be for a minimum term and you should contact NEBS for a decision on the eligibility of these Employees.

ENROLMENT EFFECTIVE DATE

NEBS will automatically enrol the Employee after the waiting period has passed. The Employer established the waiting period in their application to join NEBS. **The completion of this section is only required if you want to waive the waiting period.** Retroactive billing may apply.

PENSION EFFECTIVE DATE

The Employer has the option to waive the entire waiting period for Pension.

The Employer requests to waive the entire waiting period for the above noted Employee for Pension.

HEALTH INSURANCE EFFECTIVE DATE

The Employer has the option to waive the entire waiting period for Health benefits coverage.

The Employer requests to waive the entire waiting period for the above noted Employee for Health Benefits.

EMPLOYER CERTIFICATION

I certify this Employee is employed under the conditions detailed above and is, to the best of my knowledge, an eligible Employee for the NEBS Group Insurance and Health Benefits Plan and NEBS Pension Plan.

 Employer Signature (Person with Signing Authority) _____ Last Name, First Name _____ dd / mm / yyyy
 Employer Name – Print (Person with Signing Authority) Date

THIS SECTION IS TO BE COMPLETED BY NEBS

Comments: _____
