From the Department of Benefits

TEACHER ON CALL BENEFIT FORM

SURNAME	FIRST NAME	EMPLOYEE NUMBER

I hereby certify that I have read and understand the conditions under which I am entitled to benefits under Article 9.7.2 of the Collective Agreement. I understand that once I have received all applicable forms they must be completed and returned within 30 days of receipt of the forms.

I would like to be enrolled in the following benefit plan(s):

☐ **Medical** ☐ Single coverage $ 37.50/month
☐ Family coverage $75.00/month

☐ **Extended Health** You will apply with Pacific Blue Cross (Form must be signed by Benefits Specialist)

☐ **Dental** ☐ Single coverage $60.21/month
☐ Couple coverage $119.03/month
☐ Family coverage $195.87/month

I am aware that the costs indicated are current rates and that if they change at any time I will be responsible for payment of the increased rates retroactive to the time the rates were changed.

Signature	Date Signed

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