



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):

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

- Dental**
- Single coverage \$63.64/month
 - Couple coverage \$125.79/month
 - Family coverage \$207.00/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