ALBERTA PUBLIC SECTOR RETIREE BENEFIT PLAN

APPLICATION FOR HEALTH, TRAVEL EMERGENCY AND DENTAL PLANS – UNA RETIREES

Please complete and return to Johnson Inc. at the address below.

1. MEMBER INFORMATION (Please Print)

First Name(s)	Last Name
Address (Including Apartment/Unit Number)	

City/Town	Province	Postal Code	Sex ☐ Male ☐ Female	Former UNA Membership # _____

Date of Birth Day / Month / Year	Provincial Health Care Plan Number	Telephone Number ( )

2. PLAN INFORMATION

Extended Health Care Plan With or Without Travel Option

I wish to enrol in this plan: ☐ **Yes** ☐ **No** If **yes**, please complete:

Health Plan Option *Select One*
- ☐ **With** Emergency Travel Option
- ☐ **Without** Emergency Travel

Prescription Drugs Option *Select One*
- ☐ **Option A** ($1,200 annual drug limit)
- ☐ **Option B** ($2,000 annual drug limit)

I wish to enrol in the optional Enhanced Plan:
- ☐ **Yes** (additional premium applies)
- ☐ **No**

Dependent Coverage *Select One*
- ☐ **Single** (you alone)
- ☐ **Couple** (you and one other person)
- ☐ **Family** (you and two or more people)

Dental Plan

I wish to enrol in this plan: ☐ **Yes** ☐ **No** If **yes**, complete:

Dental Option *Select One*
- ☐ **Option A** (80% Basic and Minor, 50% Major)
- ☐ **Option B** (80% Basic and Minor)
- ☐ **Option C** (65% Basic and Minor)

Dependent Coverage *Select One*
- ☐ **Single** (you alone)
- ☐ **Couple** (you and one other person)
- ☐ **Family** (you and two or more people)

If you have selected Couple or Family coverage above, please complete the following:

Relationship to Participant	First Name	Last Name	Sex	Date of Birth	Personal Provincial Health Number	If Child(ren) over 21, indicate Student or Handicapped
Spouse						
Dependent Child						
If dependent child(ren) over age 21, please attach the name of school(s) and proof of enrolment						

3. MONTHLY PREMIUMS PAYMENT — I would like to pay my monthly premiums via:

☑ **Automatic Bank Withdrawal**

(Please include a blank personal cheque marked "VOID")

4. CONSENT AND SIGNATURE

I hereby apply for coverage under the Alberta Public Sector Retiree Benefits Plan and for Affiliate membership with the Alberta Retired Teachers' Association. I further authorize the deduction and remittance of premiums and monthly Affiliate membership fee from my bank account by Johnson Inc. and have attached a personal cheque marked "VOID". For my contribution toward the cost of these benefits I have completed, signed, and enclosed a Pre-Authorized Debit (PAD) Agreement. I further consent to disclosure, collection, and use of any information required to administer the retiree benefit program.

X _____ _____

Signature of Applicant — Date

X _____ _____

Signature of Spouse (If couple or family coverage selected) — Date

Please include your blank personal cheque marked "VOID" and completed PAD agreement.

Program Administered By:

Johnson Inc.

11120 178th Street
Edmonton, AB T5S 1P2
Health & Wellness: 877.989.2600
Home and/or Auto: 800.563.0677

06/2010