Application for Health and Dental Plans
PUBLIC/PRIVATE SECTOR

INSTRUCTIONS:

1. Complete this enrolment form and return it to ARTA's head office by mail, fax, or email as indicated on the last page.
2. This plan is not effective until the required information is complete and accurate.
3. For questions regarding the ARTA Retiree Benefits Plan, please contact ARTA's plan administrator at **arta@asebp.ca**, 780-989-8709 (Edmonton), or 1-855-444-2782.

1. Plan Member Information (Please print legibly)

Name: _____ Gender: ○ F ○ M
First Name Middle Name Last Name Maiden Name

Mailing Address: _____

City/Town: _____ Province: _____ Postal Code: _____

Phone: _____ Cell Phone: _____ Birth Date: _____
Year/Month/Day

Email: _____
Your ARTA Retiree Benefits Plan information and ID card will be sent to you by email.
If you wish to receive them by mail instead, please check here: ☐

(Applicant must be age 55 or older on the effective date of coverage)

To participate in this plan, you must be enrolled in all provincial or territorial health care plans for which you are eligible (Example: Alberta Health Care, Alberta Coverage for Seniors if you or your spouse are age 65 or over, or the BC Fair PharmaCare plan).

Public/Private sector plan participation:

☐ ACPA ☐ AIA ☐ AIC ☐ ATB ☐ ATU ☐ Capital Care ☐ CFD
☐ CHAPA ☐ CPA ☐ CUDGC ☐ CUPE ☐ LAPP ☐ Judges & Masters in Chambers
☐ MEPP ☐ MLA ☐ NEBS ☐ PSPP ☐ SFPP ☐ UNA

Date of Membership in the above noted association/organization/group: YYYY _____ MM _____ DD _____

IMPORTANT: When transferring from an employer sponsored group insurance plan or your spouse's employer sponsored group insurance plan, you must provide the following information, *including* termination dates. Coverage is effective the day after your or your spouse's plan terminates.

Insurance Company: _____ Policy Number: _____

Termination Date of Group Benefits Plan Your or Your Spouse's Plan:

GROUP EXTENDED HEALTH CARE PLAN: _____ GROUP DENTAL PLAN: _____
Year/Month/Day Year/Month/Day

OFFICE USE ONLY

Code: ARTA Membership #

ARTA Date Stamp(s) Comments:

2. Plan Selection (Please refer to the applicable plan summary for descriptions of each plan)

EXTENDED HEALTH CARE PLAN (TRAVEL **NOT** INCLUDED)	EXTENDED HEALTH CARE PLAN (TRAVEL **INCLUDED**)	DENTAL CARE PLAN (OPTIONAL)
I wish to enrol in this plan: ○ **Yes** ○ **No** If yes, please complete below.	**I wish to enrol in this plan:** ○ **Yes** ○ **No** If yes, please complete below.	**I wish to enrol in this plan:** ○ **Yes** ○ **No** If yes, please complete below.
Health Plan Option Select One ○ **Health Wise™** ○ **Health Wise Plus™**	**Health Plan Option** Select One ○ **Total Health™** ○ **Ultimate Health™**	**Dental Option** Select One ○ **Option A** (80% Basic and Minor, 50% Major) ○ **Option B** (80% Basic and Minor) ○ **Option C** (65% Basic and Minor)
Prescription Drug Option Select One ○ **$1,200 Annual Maximum** ○ **$2,000 Annual Maximum**	**Prescription Drug Option** Select One ○ **$1,200 Annual Maximum** ○ **$2,000 Annual Maximum**	
Dependant Coverage Select One ○ **Single** (you alone) ○ **Couple** (you and one other person) ○ **Family** (you and two or more people)	**Dependant Coverage** Select One ○ **Single** (you alone) ○ **Couple** (you and one other person) ○ **Family** (you and two or more people)	**Dependant 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, please complete the following:

Spouse

Name: _____ Gender: ○ F ○ M Birth Date: _____
First Name Last Name Year/Month/Day

Dependant Child

Name: _____ Gender: ○ F ○ M Birth Date: _____
First Name Last Name Year/Month/Day

Children over 21 must be a student or disabled. Proof of disability or student status is required. ○ Student ○ Disabled

Dependant Child

Name: _____ Gender: ○ F ○ M Birth Date: _____
First Name Last Name Year/Month/Day

Children over 21 must be a student or disabled. Proof of disability or student status is required. ○ Student ○ Disabled

Dependant Child

Name: _____ Gender: ○ F ○ M Birth Date: _____
First Name Last Name Year/Month/Day

Children over 21 must be a student or disabled. Proof of disability or student status is required. ○ Student ○ Disabled

3. Personal Pre-Authorized Debit Agreement

I authorize the Alberta Retired Teachers' Association (ARTA) to begin monthly automated withdrawals for payment of my benefit premiums and ARTA membership fees from the bank account identified. I understand that the following conditions apply:

a) ARTA may only assign this Personal Pre-authorized Debit Agreement ("PAD Agreement") to the Third Party Administrator contracted to administer the ARTA Retiree Benefits Plan;

b) I will pay the monthly premium and ARTA membership fee amount noted in my approval letter and a monthly statement will not be issued;

c) I will receive at least 10 days prior notification of changes in the monthly amount payable due to:
   - Premium rate adjustments, which typically occur in November, and
   - A change in benefit coverage

d) My monthly premium payment and ARTA membership fees will automatically be withdrawn from my bank account on the 10th of the month. If the 10th falls on a weekend or holiday, the withdrawal will occur on the next business day;

e) Premiums and ARTA membership fees are billed in complete months and if my benefits terminate prior to the last day of the month, I will remain responsible for the full month's premium and membership fee;

f) If there is a change in coverage that takes effect part way through a month (e.g. a change from "family" to "single" status), coverage will begin as of the date of the change. On the first day of the following month, the new premium will be charged; and

g) I will notify the Third Party Administrator of any changes to my banking information.

My authorization will remain in effect until there is 30 days written notification of termination from either myself or from ARTA. To obtain a sample cancellation form, or for more information on my right to cancel this PAD Agreement, I may contact my financial institution or visit **www.cdnpay.ca**.

If the Third Party Administrator makes a withdrawal in error or for the incorrect amount, I will notify the Third Party Administrator as soon as possible. If the Third Party Administrator is aware of an error, the error will be corrected and I will be notified as soon as possible.

I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit **www.cdnpay.ca**.

Non-Payment of Premiums

If my benefits are terminated due to non-payment of premiums, coverage will end and I will not be able to re-enrol in benefits until I make restitution, which may include payment of premiums, interest, non-sufficient fund charges and claims paid after termination. **I understand that ARTA retains the right to deny re-enrolment should coverage be terminated due to non-payment of premiums.**

It is understood that I must be an ARTA member to access the ARTA Retiree Benefits Plan. **Non-payment of ARTA membership fees will result in my ARTA benefits coverage being terminated**.

If you have any questions about this PAD Agreement, please contact a Benefit Plan Coordinator at:

Phone: 780-989-8709 (in the Edmonton area)
Toll-free: 1-855-444-ARTA (2782)
Email: **arta@asebp.ca**

4. Automatic Direct Withdrawal

Banking Information

Attach a void cheque marked "withdrawals" or proof of account ownership from your bank.

Attach void cheque here:

To be completed if premium is paid by someone other than the ARTA Member:

Account Holder Name: _____

Relationship to ARTA Member: _____

_____ Date: _____

Signature (confirms acceptance of the terms of the PAD agreement) Year/Month/Day

5. Automatic Direct Deposit

Automatic direct deposit will be used for benefit claims payments and approved refund of premium payments. Direct deposit ensures that payment is made directly into your bank account and provides:

- faster and safer service than mailing a cheque to you
- protection from delays during postal service disruptions
- automatic deposits to your bank account if you are away from home

Most financial institutions participate in direct deposit. You should check with your financial institution to make sure it can receive payment into your desired account. The financial institution's personnel will help you complete this form if necessary.

Claim deposits will be made to the same bank account unless a void cheque from a separate bank account is attached.

6. Consent

I hereby apply for ARTA membership and coverage under the ARTA Retiree Benefits Plan as indicated herein.

ARTA and the Alberta School Employee Benefit Plan (ASEBP) require the personal information contained herein in order to administer the benefits plan. It may be necessary for ARTA/ASEBP to disclose some or all of the personal information contained herein to third party service providers for these purposes. Where third party service providers are retained, appropriate contracts are in place to protect personal information.

I understand why the information is required and am aware of the risks and benefits of providing this information. I consent to the collection, use and disclosure of my personal information for the purposes identified above. I understand that I may revoke my consent at any time and acknowledge that doing so will affect my and my dependants' eligibility to receive benefits.

I understand that by virtue of the provisions of the *Personal Information Protection Act* of Alberta, my dependants are deemed to consent to the collection, use and disclosure of their personal information for the purpose of enrolment in and coverage under the group benefit plans, through me as the applicant.

7. Signature

_____ Date: _____

Signature of Applicant Date Year/Month/Day

Please ensure all information is correct, failure to do so may delay processing your application.

ARTA Retiree Benefits Plan
Send forms to: ARTA Head Office
11835 149 Street NW, Edmonton, AB T5L 2J1
Fax: 780-447-0613 **Email:** info@arta.net

Sponsored by:

ARTA
ALBERTA RETIRED TEACHERS' ASSOCIATION

ARTA Retiree Benefits Plan administered by:

asebp