PSBU Benefits Information Sheet

Date ____________________

Employee Name ____________________ **Employee ID** (if known) ____________________

Below are the bi-weekly premiums for Extended Health Coverage for the current fiscal year. Premiums may change as of July 1st each year.

Coverage Category	Single	Couple	Family
Full time Bi-Weekly Premium	$7.29	$14.59	$21.88
Part time Bi-Weekly Premium	$3.65	$7.29	$10.94

Please elect which level of health coverage you require, depending on your full time or part time employment status. Premiums will be automatically deducted from your bi-weekly pay. You cannot opt out of health coverage.

☐ Single ☐ Couple ☐ Family

If electing Couple coverage and you have multiple dependents listed below, please indicate which dependent is to receive health coverage. Couple coverage can be a spouse or a child dependent.

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All dependents entered below will be enrolled for dental benefits, upon your eligibility for dental coverage. There is no cost to an employee for dental benefits.

Dependent Information (Add or Remove)

Spouse's Name:	Last Name / First Name / Middle Initial		Date of Birth	DD / MM / YY
		Gender M ☐ F ☐	Add ☐ Remove ☐	
Dependent Name:	Last Name / First Name / Middle Initial		Date of Birth	DD / MM / YY
Full Time Student (21 – 26 years of age)	Y ☐ N ☐	Gender M ☐ F ☐	Add ☐ Remove ☐	
Dependent Name:	Last Name / First Name / Middle Initial		Date of Birth	DD / MM / YY
Full Time Student (21 – 26 years of age)	Y ☐ N ☐	Gender M ☐ F ☐	Add ☐ Remove ☐	
Dependent Name:	Last Name / First Name / Middle Initial		Date of Birth	DD / MM / YY
Full Time Student (21 – 26 years of age)	Y ☐ N ☐	Gender M ☐ F ☐	Add ☐ Remove ☐	
Dependent Name:	Last Name / First Name / Middle Initial		Date of Birth	DD / MM / YY
Full Time Student (21 – 26 years of age)	Y ☐ N ☐	Gender M ☐ F ☐	Add ☐ Remove ☐	

For Office use only

Health Coverage Level ☐ **Single** ☐ **Couple** ☐ **Family**

Completed:

H.R. ______ **Initials** ______ **Date**

Effective Date of Health Coverage ____________________

Payroll ______ **Initials** ______ **Date**

Effective Date of Dental Coverage ____________________

Class: ☐ **A (FT)** ☐ **B (PT)**

Dental Coverage Code: ______

Extended Health and Dental Benefits Plan
Eligible Dependents

DEPENDENT

Dependents eligible for benefits are:

- your spouse or common-law spouse
- each unmarried child, step-child or common-law child who is:
  - for health coverage under 22 years of age
  - for dental coverage under 21 years of age
- dependents attending an accredited educational institute, college or university on a full-time basis can remain having coverage until
  - for health coverage maximum 25 years of age
  - for dental coverage maximum 26 years of age
- a dependent who is in full-time service in any naval, military or air force is not eligible

The attainment of the maximum age specified above will not terminate the coverage on your dependent child if at the time your child is incapable of self-support due to a mental or physical handicap and relies upon you for support and maintenance.

A dependent who resides outside of Canada and the United States is not eligible for benefits.

DEPENDENT ADDITIONS

In order for coverage to commence on the date the dependent is acquired, please email HR Inquiries at hra@saskpolytech.ca within 30 calendar days after you acquire a new dependent. If the information is received more than 30 days after you acquire the dependent, coverage will commence on the first day of the month following notification of such a change.

DEPENDENT REMOVAL

Please email HR Inquiries as hra@saskpolytech.ca if a dependent is to be removed from your health/dental coverage.

NOTE

You cannot opt out of the Extended Health and Dental Benefits Plan as enrollment is a condition of your employment.