ARTA RETIREE BENEFITS PLAN
c/o ARTA HEAD OFFICE
409 - 11010 142 ST NW
EDMONTON AB T5N 2R1
780-989-8709 (Edmonton) Toll-free: 1-855-444-2782
Fax: 780-447-0613 Email: info@arta.net

Application for Health and Dental Plans – Public Sector

INSTRUCTIONS:
1. Complete this enrolment form and return it to ARTA's head office at the address above.
2. You should keep a copy of the completed form for your records.
3. If you have any questions regarding the ARTA Retiree Benefits Plan, please contact ARTA's plan administrator, ASEBP, at arta@asebp.ab.ca or via the phone numbers above.

1. PLAN MEMBER INFORMATION (PLEASE PRINT LEGIBLY)

First Name	Middle Name	Last Name

Mailing Address (including apartment/unit number)	Telephone Number

City/Town	Province/Territory	Postal Code	Cell Number

Date of Birth

Year	Month	Day

Gender
☐ Male ☐ Female

Email Address

Public sector plan participation
☐ MEPP ☐ SFPP ☐ ATB ☐ AIA ☐ CFD
☐ PSPP ☐ LAPP ☐ UNA ☐ ATU ☐ CUPE
☐ Judges & Masters in Chambers ☐ Other _____
Date of membership in the above noted association / organization / group:
YYYY _____ MM _____ DD _____

Are you, or will you be, enrolled in a government-sponsored health/drug plan, like the Coverage for Seniors plan or BC Fair PharmaCare, etc.?
☐ Yes ☐ No

Do you have a valid provincial health plan number?
☐ Yes ☐ No

IMPORTANT: If transferring from another group insurance plan or your spouse's group insurance plan, you must provide the following information, including termination dates. If approved for benefits, your effective date will be the day after your or your spouse's plan terminates.

Insurance Company_____ Policy Number_____

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

Year	Month	Day

Termination Date of Your or Your Spouse's Group Dental Care Plan:

Year	Month	Day

OFFICE USE ONLY

Code:	ARTA Membership #:
ARTA Date Stamp(s):	**ASEBP Date Stamp(s):**

2. PLAN SELECTION (PLEASE REFER TO THE PROVIDED PLAN SUMMARY FOR DESCRIPTIONS OF EACH PLAN)

EXTENDED HEALTH CARE PLAN ONLY (TRAVEL NOT INCLUDED)		EXTENDED HEALTH CARE PLAN WITH TRAVEL		DENTAL CARE PLAN	
I wish to enrol in this plan:	☐ **Yes** ☐ **No** If **yes**, please complete:	**I wish to enrol in this plan:**	☐ **Yes** ☐ **No** If **yes**, please complete:	**I wish to enrol in this plan:**	☐ **Yes** ☐ **No** If **yes**, please complete:
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 limit** ☐ **$2,000 annual limit**	**Prescription Drug Option** *Select One*	☐ **$1,200 annual limit** ☐ **$2,000 annual limit**		
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:

Relationship to Participant	First Name	Last Name	Gender	Date of Birth (YYYY-MM-DD)	Valid provincial health plan number?	Child(ren) over 21 must be a student or disabled (if disabled, proof of disability may be required)
Spouse					☐ Yes ☐ No	
Dependent Child					☐ Yes ☐ No	☐ Student ☐ Disabled
Dependent Child					☐ Yes ☐ No	☐ Student ☐ Disabled
Dependent Child					☐ Yes ☐ No	☐ 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 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 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 September, and
   - A change in benefit coverage (e.g., from "single" to "couple" or "family" coverage);
d) My monthly premium payment 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 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;

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.

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.ab.ca

4. AUTOMATIC DIRECT WITHDRAWAL

☐ **Automatic Direct Withdrawal**
Please attach a void cheque marked “withdrawals” and complete the information below, if applicable.

To be completed if you are <u>not</u> the account holder:

Account Holder Name	**Relationship to ARTA Member**

Signature (confirms acceptance of the terms of the PAD agreement)	**Date**

Attach void cheque here:

❒ **Check here if you wish deposits to be made to the same bank account.**

If you would like to use a different account for deposits than the one indicated for withdrawals, please provide a void cheque marked 'deposits' and complete the information in Section 6 – Automatic Direct Deposit .

5. MONTHLY PREMIUM PAYMENT (MEPP OR PSPP ONLY)

If you would like your premiums deducted from your pension, please complete the information below.

☐ **Deduct premiums from monthly pension (MEPP or PSPP only)**

Pension number: _____

Please provide direct deposit information and a void cheque for your claims payments by completing Section 6 – Automatic Direct Deposit.

6. 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.

To be completed if you are not the account holder:

Account Holder Name	**Relationship to ARTA Member**

Signature (confirms acceptance of the terms of the PAD agreement)	**Date**

Attach void cheque here:

7. CONSENT AND SIGNATURE

I hereby apply for coverage under the Alberta Public Sector Retiree Health & Wellness Benefits Program and for affiliate membership with the Alberta Retired Teachers' Association. **I understand that the monthly ARTA affiliate membership fee is included in the monthly benefit premiums withdrawal.**

The Alberta Retired Teachers' Association (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.

X_____ _____

Signature of Applicant **Date**

Please send your completed application form and any applicable attachments to ARTA's head office:

ARTA
409 - 11010 142 ST NW
EDMONTON AB T5N 2R1

Sponsored by: ALBERTA RETIRED TEACHERS' ASSOCIATION

ARTA Retiree Benefits Plan administered by: asebp