



## APPLICATION FOR EXTENDED HEALTH CARE, DENTAL, AND PRESTIGE TRAVEL INSURANCE PLANS

If you have any questions about the Plan, need assistance completing your application form, or need to submit written notice of change or cancellation please contact the Plan Administrator, Johnson Inc., at 1.877.989.2600 or via email at [pbservicewest@johnson.ca](mailto:pbservicewest@johnson.ca).

1. APPLICATION INFORMATION – PLEASE PRINT CLEARLY					
First Name(s)		Last Name		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address (including Apartment/Unit Number)				Telephone Number	
City/Town		Province/Territory	Postal Code	Email Address	
BCRTA Membership Number			BCRTA Membership Number (Spouse)		
Date of Birth (Day/Month/Year) DD   MM   YYYY		Provincial Health Number		Fair Pharmacare Registration Number	

2. PLAN INFORMATION	
<b>EXTENDED HEALTH CARE (EHC) PLAN*:</b>	
I wish to enrol in the EHC Plan: <input type="checkbox"/> Yes <input type="checkbox"/> No <span style="float: right;">Indicate status of coverage required: <input type="checkbox"/> Single <input type="checkbox"/> Couple <input type="checkbox"/> Family</span>	
I am enrolled in a Pharmacare Plan: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Prescription Drug Option (select one):</b>	
Plan 1 – If <u>either</u> you <u>or</u> your spouse was born in 1939 or earlier: <input type="checkbox"/> Drug Option A: \$1,200 per household <span style="float: right;"><input type="checkbox"/> Drug Option B**: \$2,500 per household</span>	
Plan 2 – If you <u>and</u> your spouse were born in 1940 or later: <input type="checkbox"/> Drug Option A: \$2,000 per household <span style="float: right;"><input type="checkbox"/> Drug Option B**: \$4,000 per household</span>	
<i>*NOTE: If your province or territory of residence has a Pharmacare Plan, these insurance coverages are only available if you are enrolled in the Pharmacare Plan.</i>	
<i>**NOTE: Once you enrol in Drug Option B, you must remain in the Plan for 24 months.</i>	
<b>PRESTIGE TRAVEL INSURANCE (only available with EHC):</b>	
I wish to enrol in Prestige Travel Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No <span style="float: right;">If “yes”, check the appropriate boxes and complete the details below as required.</span>	
<i>NOTE: You must enrol in the EHC Plan to choose Prestige Travel Insurance. Your coverage option (Single, Couple or Family) under Prestige Travel Insurance will match the status of coverage selected under the EHC Plan.</i>	
<b>Base Plan (select one):</b> <input type="checkbox"/> 62-day Base Plan <input type="checkbox"/> 93-day Base Plan This insurance provides an unlimited number of trips within Canada of any duration, and an unlimited number of trips outside Canada of up to 62 or 93 consecutive days, depending on your Base Plan selection.	
<b>Deductible Option (select one):</b> <input type="checkbox"/> No Deductible <input type="checkbox"/> \$1,000 Deductible (save 10% on Base Plan premiums) <i>Your deductible option can only be changed at the start of each new policy year, September 1st.</i>	
<input type="checkbox"/> <b>Supplemental Plan</b> – for a single trip of longer than 93 consecutive days outside of Canada, including the date you leave Canada for a period of more than 93 consecutive days and the date you return to your province or territory of residence. <i>A 93-day Base Plan is required in order to purchase a Supplemental Plan.</i>	
Date of departure from Canada DD   MM   YYYY	Date of return to your home province or territory DD   MM   YYYY
Supplemental Plan premiums are based on the Total Trip Duration increments of 94-98, 99-107, 108-122, 123-137, 138-152, 153-167, 168-182, 183-197 and 198-212 days. For example, a trip of 100 days would have the same premium as a trip of 104 days, as Supplemental Plans have a set premium for a Total Trip Duration ranging anywhere from 99 to 107 days.	
<b>DENTAL PLAN*:</b>	
I wish to enrol in the Dental Plan (80% Basic, 80% Minor, 50% Major): <input type="checkbox"/> Yes <input type="checkbox"/> No	
Indicate status of coverage required: <input type="checkbox"/> Single <input type="checkbox"/> Couple <input type="checkbox"/> Family	
<i>*NOTE: You must maintain membership in the Dental Plan for 24 months.</i>	
Check here if you are maintaining other existing EHC coverage in <u>addition</u> to this Plan*: <input type="checkbox"/> Are you the: <input type="checkbox"/> Member OR <input type="checkbox"/> Spouse	
Insurance Company: _____	Policy Number: _____
<i>*NOTE: Coverage for this Plan will become effective the 1<sup>st</sup> day of the month following the date of receipt of this form.</i>	
If you are <u>not</u> maintaining additional EHC coverage, when transferring from an employer sponsored group insurance plan or your spouse’s employer sponsored group insurance plan, <u>you must</u> provide the termination date (in space below). Coverage for this Plan is effective the day after your or your spouse’s plan terminates.	

**IMPORTANT – YOU MUST COMPLETE AND SIGN SECTION 4 ON THE REVERSE FOR COVERAGE TO BE IN FORCE**

Termination Date of Your or Your Spouse's group benefits plan*:	DD	MM	YYYY
*NOTE: Those with existing group EHC benefits must apply within <u>60 days</u> of losing existing employer coverage. After 60 days of prior plan termination, evidence of insurability is required.			

If you have selected Couple or Family Coverage, please provide Spousal/Dependent Details below:

First Name(s)	Last Name	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Provincial Health Number	Date of Birth DD MM YYYY	Dependents age 21+ <input type="checkbox"/> Full Time Student age 24 or less <input type="checkbox"/> Disabled
First Name(s)	Last Name	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Provincial Health Number	Date of Birth DD MM YYYY	Dependents age 21+ <input type="checkbox"/> Full Time Student age 24 or less <input type="checkbox"/> Disabled
<i>For additional Dependents, please provide information on a separate page.</i>		

**3. MONTHLY PREMIUM PAYMENT**

**Automatic Bank Withdrawal.** I have enclosed a **sample cheque marked "VOID"**. I authorize Johnson Inc., the Plan Administrator, to make monthly deductions (including mid-term adjustments and arrears) from the bank, trust company or credit union account shown on the cheque. Deductions are withdrawn one month in advance, for example, the August 5<sup>th</sup> deduction pays for September coverage.

**4. CONSENT AND SIGNATURE**

**I hereby certify** that I am a Member in good standing with the British Columbia Retired Teachers' Association and my eligibility ceases upon termination of my BCRTA membership.

**I acknowledge** to be eligible for insurance under the Extended Health Care (EHC) Plan, the Dental Plan and/or Prestige Travel Insurance, I must: a) be a member, or a spouse or dependent of a member; b) be a Canadian resident; and c) be insured under my Provincial or Territorial Health Insurance Plan and **I confirm** that all persons listed on this application are eligible for the selected plan(s). **I also acknowledge** that the EHC Plan requires members to be enrolled in their provincial Pharmacare Program (if applicable).

**I authorize** that my premium for this insurance, including any mid policy year adjustments, arrears and renewals, be deducted in monthly amounts due on or after this date of application. I understand that my policy will be automatically cancelled should Johnson Inc. receive two or more Non-Sufficient Funds (NSF) notices on my account.

**I understand** that EHC, Dental and Prestige Travel Insurance coverage will begin on the day after my current group benefits terminate OR, if maintaining coverage under my current group plan, on the 1<sup>st</sup> of the month following the date of receipt of application. If applying as a late applicant, I understand coverage will become effective the date the completed application is approved by the Insurer.

**I also understand** that unless I advise Johnson Inc. in writing to the contrary, the coverage I have selected **will remain in effect for each policy year thereafter**. Johnson Inc. will provide me with notification before the beginning of each subsequent policy year, which is September 1<sup>st</sup>.

**I authorize** my "Group", the British Columbia Retired Teachers' Association, my "Plan Administrator" Johnson Inc., my "Insurers" Desjardins Financial Security and Royal & Sun Alliance Insurance Company of Canada (collectively, the "Providers") to collect, use, maintain and disclose my financial, medical and other personal information, including the information relating to any spouse or dependent who may be the subject of this application (the "Information"), for the purposes of the Extended Health Care Plan, Dental Plan and/or Prestige Travel Insurance (the "Plans") administration and audit and the assessment, investigation, management, processing and/or underwriting of this application and any claims under the Plans (collectively, the "Purposes"). **I authorize** any person with Information, including any medical and health professional, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer investigative agency and any administrators of other benefits programs to collect, use, maintain and exchange this Information with each other and with the Providers and any replacement Plan Administrator, Insurer, Administrator approved by my Group, for the Purposes. **I understand** that any coverage will not become effective until approved by the Providers. **I authorize** the use of my Provincial Health Number and any Group Member ID for the purposes of identification and administration. For further information on how Johnson Inc. manages your personal information, please visit: <https://www1.johnson.ca/protecting-your-privacy>. For further information on how Royal & Sun Alliance Insurance Company of Canada manages your personal information, please visit: <https://www.rsagroup.ca/your-privacy/privacy-policy>.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Spouse (if Couple or Family coverage selected)

\_\_\_\_\_  
Date

PLEASE FORWARD YOUR APPLICATION TO: JOHNSON INC.  
GROUP BENEFITS SERVICE  
PO BOX 4005 STN A  
TORONTO ON M5W 0M7

Johnson Inc. is a licensed insurance intermediary. Johnson administers the EHC Plan, Prestige Travel Insurance and Dental Care ("Options"). The EHC Plan and Dental Care Option are underwritten by Desjardins Financial Security ("DFS"). Coverage under the EHC Plan is subject to proof of enrolment in the applicable Provincial Pharmacare program. Prestige Travel Insurance is underwritten by Royal & Sun Alliance Insurance Company of Canada ("RSA"). Valid provincial or territorial health plan coverage required. Johnson and RSA share common ownership. Travel assistance is provided by Global Excel Management Inc. Eligibility requirements, limitations and exclusions may apply and/or may vary by province or territory. Policy wordings prevail.

## EXPLANATION OF AUTOMATIC BANK DEDUCTION

Automatic Bank Deduction is a convenient way of paying your premium monthly. If you have more than one benefit plan or travel policy with Johnson Inc. ("Johnson") (or home and/or auto insurance policy) and if you are using the same account, all payments will be combined into a single monthly deduction, regardless of the renewal date.

### **Deductions**

Deductions will be withdrawn on the 5<sup>th</sup> of each month or as a single payment, as applicable, but could be delayed due to processing with your own financial institution. Please note, your first deduction may include premiums to provide coverage from your effective date. Your coverage will remain in place unless you become ineligible or you cancel.

### **Policy Changes and Premium Changes**

A change to a policy, including any renewal, cancellation, addition of new policies or change in coverage(s) can affect the amount of premium owing and likewise the amount of your deduction. Any such change will be explained to you in a Confirmation of Coverage letter. To allow for sufficient processing time, we recommend that any request for change in coverage(s) or cancellation be received in our office by the 15<sup>th</sup> of the month in order to affect the next billing cycle. If you require further details, don't hesitate to call your Service Supervisor, whose contact information will appear on your documents.

### **Insufficient Funds / Stopped Payment**

When your deduction is withdrawn on the 5<sup>th</sup> of each month, if it is returned by your financial institution due to Insufficient Funds or Funds Not Cleared, we will attempt to collect the same amount from your account 5-7 business days later. This will give you another opportunity to have the funds available. If, on the 2<sup>nd</sup> attempt, your deduction is returned by your financial institution, your deduction will be processed as discussed below. Please note, your financial institution may charge you for each unsuccessful withdrawal attempt, depending on your fee plan.

Any deduction that is returned by your financial institution due to Insufficient Funds OR Stopped Payment will be subject to a handling fee. The missed deduction, along with the handling fee, will be collected with your next regular deduction. There are some exceptions for certain coverage, such as Medoc travel insurance, for which a missed deduction and handling fee will be spread equally over the remaining policy term deductions. In the event of multiple missed deductions, your policy may be cancelled by registered mail, in accordance with provincial regulations. You can arrange with your bank to have overdraft protection to prevent insufficient funds.

### **Important - Changes in Your Bank Account**

If you make a change to your financial institution or account, you should advise us by the 15<sup>th</sup> of the month - this will ensure your next deduction is maintained without interruption. Or, alternatively, you could leave your old account open with sufficient funds until you see the deduction has been cleared.

**PERSONAL PRE-AUTHORIZED DEBIT (“PAD”) PLAN AGREEMENT**

**PLEASE COMPLETE THE FOLLOWING REQUIRED INFORMATION (PREPARED IN ACCORDANCE WITH CANADIAN PAYMENTS ASSOCIATION, RULE H1), SIGN AND RETURN, WITH A VOID CHEQUE. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT JOHNSON INC.**

- You have chosen to pay your personal benefit plan or travel insurance premium(s) by pre-authorized bank debit (“deduction” or “debit”). If you have more than one benefit plan or travel policy with Johnson Inc. (“Johnson”) (or home and/or auto insurance) and if you are using the same account, all payments will be combined into a single monthly deduction, regardless of the renewal date. The deduction may appear on your bank statement as Johnson/Unifund or as indicated below (\*).
- I hereby authorize the financial institution designated to debit my account each month for all amounts payable to Johnson related to my benefit plan(s) or travel policy(ies). I understand that any change(s) to my coverage(s), including any renewal or addition of policy(ies), benefits or coverage can affect the amount of premium owing, and likewise will impact the amount of my monthly deduction.
- **Where there is a change to my policy, coverage or benefits, where I have missed a payment, or where I have given instructions to change the amount, I hereby waive the requirement to receive prior written notice of the date and amount of the deduction. However, written notice of any change in the amount of my deduction will be provided to me in all cases and in advance wherever possible.**
- This authority is to remain in effect until Johnson has received written notification from me of change or termination. I can revoke or revise this authorization at any time by providing any such notification by the 15th day of the month in order to take effect on the next scheduled deduction, at the address listed below. I may obtain a sample cancellation form or more information on my right to cancel a PAD Agreement at my financial institution or by visiting [www.cdnpay.ca](http://www.cdnpay.ca).
- **Johnson may assign this authorization to any of its affiliated companies, successors or assigns upon providing written notice to me.**
- 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 PAD that is not authorized or is not consistent with this PAD Agreement. To obtain a form for a Reimbursement Claim, or for more information on my recourse rights, I may contact my financial institution or visit [www.cdnpay.ca](http://www.cdnpay.ca).
- This is not a contract of or for insurance or benefits. This agreement only applies with respect to the method of payment. Termination of this authorization does not terminate my insurance or benefit contract(s).
- Privacy: I provide consent on behalf of myself and all named insureds under my policy(ies) for the collection, use and disclosure of our personal information for the purposes of communication, assessing my application(s), evaluating claims, detecting and preventing fraud, marketing of other insurance related products and services available, customer surveying, and otherwise as may be required by law. Some of your personal information may be stored and/or processed by one or more service providers outside of Canada. For more information about our policies and practices regarding our use of personal information and of service providers outside of Canada, please contact our Privacy Officer. A full copy of our privacy statement and the contact information of our Privacy Officer is available at [www.johnson.ca](http://www.johnson.ca).

**Please Print**

Group Name:

Policyholder Name

Street Number:  Street Name :

City/Town  Province :  Postal Code

Phone Number Residential  Phone Number Business  Extension

Cell Number

**For Office Use Only:**

Group Number (For office use only):

Member Number (For office use only):

*Continued on reverse*

\*The deduction may also appear on your bank statement as: Servus/Johnson, Meyer's Ins/Johnson Inc., Morgex/Johnson, or Cummings-Cossitt/Unifund.

**Please Provide Financial Information (Please Print)**

Financial Institution

Street Number :

Street Name :

City/Town

Province:

Postal Code

Account Holder Name

**SIGN  
HERE**

Account Holder Signature

Date (DD/MM/YYYY)

For joint account, all depositors must sign if more than one signature is required on cheques issued against the account. If you choose to communicate by email or fax, please be reminded that there is a risk of misdirection or interception in sending personal information by email or fax.

**Please Provide Cheque Information As Noted In Example Below**

Branch Transit: @ 2 3 4 5	Bank Number: @ 2 3	Account Number: @ 2 3 4 5 6 7 8 9
<input type="text"/>	<input type="text"/>	<input type="text"/>

**VOID CHEQUE REQUIRED**

**Johnson Inc.**  
**Group Benefits Administration - West**  
PO Box 4005 STN A  
Toronto, ON M5W 0M7  
Tel: 780.413.6536  
Toll-Free: 1.877.989.2600  
Fax: 1.866.226.1430

\*The deduction may also appear on your bank statement as: Servus/Johnson, Meyer's Ins/Johnson Inc., Morgex/Johnson, or Cummings-Cossitt/Unifund.