THE UNIVERSITY OF LETHBRIDGE

Extended Health and Dental Benefits Form

Please complete this form, sign and return to Pension and Benefits. You may wish to retain a copy for your record. Please keep Pension & Benefits informed of any changes in your family status (i.e. new dependents, change on dependents status, etc.)

☐ Initial Enrollment ☐ Change

_____
Effective Date (HR use only)

1. Employee Information

Last Name	First Name	Middle Initial	Date of Birth	Province

Employee ID	Employee Group	Type of Contract	Gender	Coverage

2. Required Family Information for Extended Health and Dental Benefits

	Last Name	First Name	Middle Initial	Date of Birth	Gender	Relationship Code
Spouse						
Dependent						
Dependent						
Dependent						
Dependent						
Dependent						

3. Coordination of Benefits (COB)

If your spouse have Extended Health and/or Dental coverage under another group plan, you can combine the benefits coverage. This allows a plan member to receive up to the maximum eligible amount for eligible prescription drug, dental and health COB claims.

Please call Alberta Blue Cross Customer Services for assistance with COB or any aspect of your Alberta Blue Cross benefits: Lethbridge Office 403-328-6081.

4. Opting Out due to duplicate Extended Health and/or Dental Benefits

If you are covered for similar benefits under another plan, you may choose to opt out of the University of Lethbridge Extended Health and/or Dental benefits for yourself and/or your dependents. Please attach a copy of this coverage card.

1. I wish to opt out of Extended Health benefits for:
2. I wish to opt out of Dental benefits for:

Spouse Employer	Spouse Insurance Company	Policy Number	Spouse's ID number

In the event this other coverage is discontinued, I agree to become covered under the group policy carried by the University for the above waived benefit(s) within 31 days of the end of the other coverage. If I do not, I may have to provide medical evidence of insurability to be covered at any later date.

5. Employee Authorization

I hereby apply for insurance under the group policy carried by the University of Lethbridge subject to all the terms, conditions and provisions of said policy. The foregoing answers are, to the best of my knowledge and belief, true, complete and correctly recorded. If a contribution towards the premium is required, I authorize the necessary deductions from my earning.

Employee Signature _____ Date

The personal information collected on this form is subject to the provisions of the Alberta Freedom of Information and Protection of Privacy Act 9FOIPP) and is collected for the purpose of administering benefit/pension programs for employees. Information collected may be forwarded to the corresponding institutions for the purpose of administering the programs. If you have any questions about the collection of this information, contact Human Resources, University of Lethbridge, 4401 University Drive, Lethbridge. Alberta, T1K 3M4, phone 329-2274.