

# OUR FLEX BENEFITS PROGRAM

Going Places  
Together.

RED RIVER COLLEGE  
OF APPLIED ARTS, SERVICE AND TECHNOLOGY

## Flex Benefits Continuation Form (Pre-Authorized Debit)

**Enrolment Deadline: 2 weeks**  
**Please send to Human Resource Services**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Department: \_\_\_\_\_ My Employee ID is: \_\_\_\_\_

My True Dependent Status is (circle one): **Single** **Family**

Continue my coverage under the Flex Benefits Program (circle one): **Yes** **No** (If no, sign, date & return form)

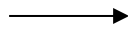
If YES, I am currently in *Flex Option*  
(circle one):

Employee Monthly Cost: (single/family)

Employee Annual Cost: (single/family)

	1	2	3	4	5
Employee Monthly Cost: (single/family)	No Cost	\$16.58 single / \$36.42 family	No Cost	No Cost	\$49.92 single / \$109.75 family
Employee Annual Cost: (single/family)	No Cost	\$199 single / \$437 family	No Cost	No Cost	\$599 single / \$1,317 family

Employee Monthly Cost



\$

I authorize Red River College to withdraw any funds owing to Red River College on a monthly basis from the account described below. This authority will remain in effect until specifically revoked. Revocation shall be in writing to RRC Financial Services. If there are insufficient funds to cover the cost of benefits, Red River College will terminate benefit coverage as of the end of the month of the last payment received.

Funds can only be withdrawn from either a chequing or savings account.

**Chequing Account** – attach a void cheque.

**Savings Account** – provide the following information:

Branch Transit #: \_\_\_\_\_ Institution #: \_\_\_\_\_ Bank Account #: \_\_\_\_\_

Bank Name: \_\_\_\_\_

Bank Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

For Office Use Only:			
Div	Class	FI/PT	S/F

Payroll Authorization: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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## ENROLMENT FORM

**Great-West Life**  
ASSURANCE COMPANY

Policy No. 57353 – Flex Health, Dental & Health Spending Account  
Policy No. 160733 – Global Medical Assistance

### EMPLOYEE INFORMATION

Surname:		Given Name and Middle Initial(s):		Employee Number:	
Birth Date (month/day/year):	Gender: <i>Male</i> <i>Female</i> <i>Undisclosed</i> <i>Other</i>	Home Telephone: (   ) (   )		Work Telephone: (   ) (   )	
Address:		City :	Province:	Postal Code:	

**DEPENDENT INFORMATION IF APPLICABLE** - Employees must enroll according to their true dependent status.

True Dependent Status: <i>Single</i> OR <i>Family (having at least 1 dependent)</i>						
<b>SPOUSE</b>						
Surname (if different from Employee Surname):		<b>What group benefits coverage does your spouse have through his/her employer?</b> <i>Where applicable, benefit payments will be coordinated between this plan and your spouse's plan.</i>				
Given Name and Middle Initial(s):		<b>Spousal Group Coverage</b>	<b>Single</b>	<b>Family</b>	<b>Waived</b>	<b>None</b>
<input type="checkbox"/> <i>Legally Married</i> <input type="checkbox"/> <i>Common Law</i> If common law, please provide commencement date of cohabitation (month/day/year):		Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Birth Date (month/day/year):		Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gender: <i>Male</i> <i>Female</i> <i>Undisclosed</i> <i>Other</i>		Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### UNMARRIED DEPENDENT CHILDREN (Please use back of this page if additional space required.)

Surname (if different from Employee)	Given Name and Middle Initial(s)	Gender				Birth Date (month/day/year)	Full-time Student		Disabled prior age 22	
		Male	Female	Undisclosed	Other		Yes	No	Yes	No
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I hereby apply for coverage under the group benefits plan issued by Red River College. I authorize Red River College:

- To deduct from my pay the plan member contributions required under the plan, if applicable; and
- To exchange personal information, when necessary to determine my eligibility for coverage and to administer the plan.

If applying for coverage for my spouse and/or dependents, I confirm that I am authorized to act on their behalf. I agree that a photocopy or electronic copy of this application is as valid as the original. I certify that the information given is true, correct and complete to the best of my knowledge.

Employee Signature: \_\_\_\_\_ Date (month/day/year): \_\_\_\_\_

**Please submit completed form to:**  
Human Resource Services - Pay & Benefits Administration  
C409-2055 Notre Dame Avenue, Winnipeg, MB, R3H 0J9  
Telephone: 632-2319

<b>OFFICE USE ONLY:</b>	<b>Benefits Application completed</b>
	Yes _____ No _____
<b>Eff Date:</b> _____	<b>Payroll Authorization:</b> _____
	(month/day/year)