OUR FLEX BENEFITS PROGRAM

Going Places Together.

RED RIVER COLLEGE

# 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):

| | 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Funds can only be withdrawn from either a chequing or savings account.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 | FT/PT | S/F |
|---|---|---|---|
| | | | |

**Payroll Authorization:** _____

_____ _____

Signature Date

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## ENROLMENT FORM

The 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: *Male* ☐ *Female* ☐ *Undisclosed* ☐ *Other* ☐ | 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: ☐ *Single* *OR* ☐ *Family (having at least 1 dependent)*

**SPOUSE**

| Surname (if different from Employee Surname): | **What group benefits coverage does your spouse have through his/her employer?** ***Where applicable, benefit payments will be coordinated between this plan and your spouse's plan.*** | | | | |
|---|---|---|---|---|---|
| Given Name and Middle Initial(s): | ***Spousal Group Coverage*** | ***Single*** | ***Family*** | ***Waived*** | ***None*** |
| ☐ *Legally Married* ☐ *Common Law* If common law, please provide commencement date of cohabitation (*month/day/year*): | Health | ☐ | ☐ | ☐ | ☐ |
| | Drugs | ☐ | ☐ | ☐ | ☐ |
| Birth Date (*month/day/year*): | Vision | ☐ | ☐ | ☐ | ☐ |
| Gender : *Male* ☐ *Female* ☐ *Undisclosed* ☐ *Other* ☐ | Dental | ☐ | ☐ | ☐ | ☐ |

**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* |
| | | ☐ | ☐ | ☐ | ☐ | | ☐ | ☐ | ☐ | ☐ |
| | | ☐ | ☐ | ☐ | ☐ | | ☐ | ☐ | ☐ | ☐ |
| | | ☐ | ☐ | ☐ | ☐ | | ☐ | ☐ | ☐ | ☐ |
| | | ☐ | ☐ | ☐ | ☐ | | ☐ | ☐ | ☐ | ☐ |
| | | ☐ | ☐ | ☐ | ☐ | | ☐ | ☐ | ☐ | ☐ |

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**

**OFFICE USE ONLY:**

**Benefits Application completed**

**Yes**_____ **No** _____

**Eff Date:** _____ **Payroll Authorization:**_____
*(month/day/year)*