Public Education Benefits Trust

Optional Life Insurance

Coverage: Available to employee and spouse in units of $10,000 to a maximum benefit of $300,000, subject to satisfactory evidence of insurability

Monthly rate: Ask your district benefits administrator whether the 12-month or 10-month rates will apply for you or your spouse

12 Month Rates per $10,000

Age	Male		Female	
	Smoker	Non-Smoker	Smoker	Non-Smoker
Under age 35	0.80	0.50	0.40	0.30
35 – 39	0.90	0.50	0.50	0.40
40 – 44	1.20	0.70	0.80	0.50
45 – 49	2.00	1.10	1.30	0.80
50 – 54	3.70	1.80	2.20	1.30
55 – 59	5.90	3.30	3.40	2.20
60 – 64	8.60	5.00	4.80	3.30
65 – 69	21.60	10.70	15.70	7.90

10 Month Rates per $10,000

Age	Male		Female	
	Smoker	Non-Smoker	Smoker	Non-Smoker
Under age 35	0.96	0.60	0.48	0.36
35 – 39	1.08	0.60	0.60	0.48
40 – 44	1.44	0.84	0.96	0.60
45 – 49	2.40	1.32	1.56	0.96
50 – 54	4.44	2.16	2.64	1.56
55 – 59	7.08	3.96	4.08	2.64
60 – 64	10.32	6.00	5.76	3.96
65 – 69	25.92	12.84	18.84	9.48

Premium is calculated based on the employee's age, sex and smoking status for Employee Optional Life and on the spouse's age, sex and smoking status for Spouse Optional Life. Premium changes on the first of the month coincident with or next following the birthday, which moves the employee or spouse to the next age band.

Coverage is reduced by 50% at age 65 and terminates at age 70.

Optional Child Life

Coverage: Available in units of $2,500 up to $10,000. Evidence of insurability is not required for the first two units of coverage. Coverage applies to all eligible dependent children.

Monthly Rate: $0.50 per $2,500 (12-month rate)
$0.60 per $2,500 (10-month rate)

PEBT Optional Life Application Checklist

Disability and Life Claims Department
Po Box 7000 Vancouver, BC V6B 4E1
Telephone : 604-419-2000
Toll-free : 1-877-PAC-BLUE(722-2583)
Fax : 604-419-8055

Optional Life Application Checklist:

To complete the Statement of Health form, first have your School District Benefits Administrator complete Part 1.

You will need to complete Parts 2-7 after the benefits administrator completes Part 1.

Ensure that all information requested is provided to avoid delays in application processing.

Benefits Administrators: Check-off Member Optional Life and/or Spouse Optional Life *(depending on eligibility and Member request).* Coverage can be selected in units of $10,000 up to a maximum of $300,000.

The form will need to be signed and dated before submission to PBC.

Submit the Statement of Health directly to PBC using the address on the top of the form.

Beneficiary Nomination: Review your beneficiary nominations, made either on your PEBT Enrolment Form or subsequent PEBT Change Form, and update as necessary using a PEBT Change Form. Sign and date the Change Form and provide it to your School District Benefits Administrator to maintain in your personnel file. The beneficiary for any spouse or child optional life coverage will be the Member.

The PEBT Change Form is available on the PEBT website at www.pebt.ca or from your School District Benefits Administrator.

PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

STATEMENT OF HEALTH

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | 604 419-2000 or Toll Free 1 877 PAC-BLUE | Fax: 604 419-8055

APPLICANTS — Please complete PART 2-7 of this application and return to the address above.
If applying for Optional Life coverage, please also complete a Beneficiary Designation form.
EMPLOYERS/PLAN ADMINISTRATORS — Please complete PART 1 of this application.

PART 1 — EMPLOYER/PLAN ADMINISTRATOR

Policy number	Name of company/organization		Member ID number	
Division	Sub-division (if applicable)	Class	Section ID (if applicable)	Plan Code (if applicable)
Member's occupation			Employment type ☐ Full-time ☐ Part-time ☐ Retired ☐ Hour bank	
Payroll number (if applicable)	Date of full-time hire or rehire (mm-dd-yyyy)		Member salary $ ☐ Hourly ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually	Hours per week

Actively at work? ☐ Yes ☐ No If no, please provide details:

Reason for application
☐ New benefit ☐ Newly hired ☐ Life event ☐ Late enrollment ☐ Increase coverage ☐ Annual re-enrollment

Type of insurance and amount applying for

☐ Life/Accidental death & dismemberment $ _____
☐ Dependent life $ _____
☐ Extended health care
☐ Dental
☐ Short-term disability $ _____
☐ Long-term disability $ _____
☐ Critical illness $ _____
☐ Member Optional Life $ _____
☐ Spouse Optional Life $ _____
☐ Member Optional Critical Illness $ _____
☐ Spouse Optional Critical Illness $ _____

PART 2 — APPLICANT INFORMATION

Legal first name	Preferred first name	Last name	Middle initial
Street address	City	Province	Postal code
Place of birth	Email address	Daytime phone number (10 digits)	
Physician name			
Physician address	City	Province	Postal code
Physician phone number (10 digits)	Physician fax number (10 digits)		

PART 3 — INDIVIDUALS TO BE COVERED

Please provide the information requested in the table below.

FIRST NAME	LAST NAME	MIDDLE INITIAL	BIRTHDATE	SEX	HEIGHT	WEIGHT
Applicant			(mm-dd-yyyy)	☐ M ☐ F		
Spouse			(mm-dd-yyyy)	☐ M ☐ F		
First child			(mm-dd-yyyy)	☐ M ☐ F		
Second child			(mm-dd-yyyy)	☐ M ☐ F		
Third child			(mm-dd-yyyy)	☐ M ☐ F		
Fourth child			(mm-dd-yyyy)	☐ M ☐ F		
Fifth child			(mm-dd-yyyy)	☐ M ☐ F		
Sixth child			(mm-dd-yyyy)	☐ M ☐ F		

PART 4 — GENERAL DECLARATION

Please provide the information requested in the table below.

1a. Have you or your spouse used any form of tobacco, tobacco cessation products, marijuana, nicotine, e-cigarettes, or nicotine replacement products in the last 12 months? ☐ Yes ☐ No If yes, please provide details: _____

1b. Have you or your spouse had any weight change within the last 12 months? ☐ Yes ☐ No If yes, please provide details:

Member	☐ Gained ☐ Lost	_____ ☐ lbs ☐ kg	Reason
Spouse	☐ Gained ☐ Lost	_____ ☐ lbs ☐ kg	Reason

	MEMBER	SPOUSE	CHILD
2. Have you or your dependents ever applied for or received benefits, compensation or pension due to sickness or injury? If yes, provide details _____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. Have you or your dependents been absent from work because of sickness or injury during the last six months? If yes, provide details _____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. Do you or your dependents now have or are you applying for other life or disability income insurance? If yes, type of insurance: _____ Amount: $ _____ Benefit and elimination periods (where applicable): _____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5. Are you aware of any symptoms or complaints for which you have not yet consulted a physician or received treatment? If yes, provide details _____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
6. Have you engaged or do you intend to engage in any hazardous sports such as motor racing, scuba diving, or hang gliding or have you flown in an aircraft other than as a fare-paying passenger? If yes, provide details: _____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
7. Have you or your dependents had a request for life or health insurance declined, postponed, rated, or restricted in any way? If yes, provide details: _____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

PART 5 — MEDICAL DECLARATION: Complete questions 1–5

1. Have you or your dependents ever consulted a doctor or practitioner because of, suffered from, been treated for or had any indication of any of the following medical conditions? If you are unsure how to answer any of these questions, please consult your doctor.

	MEMBER	SPOUSE	CHILD
• **Chest or heart conditions** Including circulatory, heart or vascular disease, high blood pressure, elevated cholesterol, heart attack, angina, stroke or TIA (mini-stroke), blood and lung disorders.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• **Diabetes and gland disorders** Including diabetes (IDDM-Type 1) or (NIDDM-Type 2), hormonal or thyroid conditions.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• **Gastrointestinal conditions** Including stomach, intestinal or liver conditions (including hepatitis A, B, C or B carrier state), colitis, Crohn's disease, irritable bowel syndrome, diverticulitis, colon polyps, ulcers, hernia, GERD (acid reflux or persistent heartburn).	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• **Respiratory or Lung conditions** Including allergies, Asthma, Bronchitis, Chronic Obstructive Pulmonary Disease (COPD), sleep apnea.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• **Musculoskeletal conditions** Including osteoarthritis or rheumatoid arthritis, osteoporosis, bone density loss or back, neck, limb or joint or muscle pain (including fibromyalgia).	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• **Immunological conditions** Including acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) or any other immunological disorder, or any positive test results indicating exposure to the AIDS virus.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

	MEMBER	SPOUSE	CHILD
• **Genitourinary conditions** Including kidney, bladder, infertility or reproductive disorders, menopause, endometriosis, sexually transmitted disease(s) or recurring infections (cold sore/herpes/shingles).	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• **Neurological/nervous conditions** Including Alzheimer's, dementia, Parkinson's, epilepsy, multiple sclerosis, seizures, paralysis, chronic headaches or migraines, or chronic fatigue syndrome.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• **Mental health conditions** Including anxiety, depression, emotional disorders, eating disorders, attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD).	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• **Cancer** Including tumors (malignant or benign), leukemia.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• **Lifestyle** Including use of marijuana, cocaine, narcotics, hallucinogens, or similar drugs not prescribed by a physician and/or used tobacco products (cigarettes, chewing tobacco, snuff and nicotine replacement products) and/or undergone treatment for alcoholism or a drug habit.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. Have you or your dependents had any physical impairments, deformities, hospitalization or illness not covered in question 1?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

3. If yes to either question 1 or 2, please give details:

NAME	CONDITION/ DISORDER	DIAGNOSIS DATE	RECOVERY DATE	MEDICATION/TREATMENT	PHYSICIAN NAME, ADDRESS AND PHONE NUMBER
		(mm-dd-yyyy)	(mm-dd-yyyy)		
		(mm-dd-yyyy)	(mm-dd-yyyy)		
		(mm-dd-yyyy)	(mm-dd-yyyy)		
		(mm-dd-yyyy)	(mm-dd-yyyy)		
		(mm-dd-yyyy)	(mm-dd-yyyy)		
		(mm-dd-yyyy)	(mm-dd-yyyy)		
		(mm-dd-yyyy)	(mm-dd-yyyy)		
		(mm-dd-yyyy)	(mm-dd-yyyy)		
		(mm-dd-yyyy)	(mm-dd-yyyy)		

4. Are you or your dependents taking any prescribed medication? If yes, provide name of medication(s) and reason for use in space provided below.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

NAME	NAME OF MEDICATION	DOSAGE	FREQUENCY

PART 5 — MEDICAL DECLARATION: Complete questions 1–5 (continued)

	MEMBER	SPOUSE	CHILD
5. Have any of your or your spouse's immediate family members (parents, brothers, sisters) had heart disease, heart attack, high blood pressure, polycystic kidney disease, familial polyposis of the bowel, stroke, diabetes, cancer (specify type below), multiple sclerosis, Huntington's Chorea, Alzheimer's, Parkinson's, ALS (Amyotrophic Lateral Sclerosis) or any hereditary disease? If yes, please complete your family's medical history below:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

FAMILY MEMBER	DETAILS OF ANY DISORDER (INCLUDING AGE OF DIAGNOSIS)	CAUSE AND AGE OF DEATH (IF APPLICABLE)
Member's father		
Member's mother		
Member's sibling		
Member's sibling		
Spouse's father		
Spouse's mother		
Spouse's sibling		
Spouse's sibling		

PART 6 — DECLARATION AND AUTHORIZATION TO COLLECT AND COMMUNICATE PERSONAL INFORMATION

I declare all recorded answers included on this form are full, complete and true as of this date.

I authorize any person or institution, including the Medical Information Bureau, that has any records or knowledge of my health or my spouse's health to give Pacific Blue Cross and its reinsurers any such information. I understand this information will be used by Pacific Blue Cross to determine my eligibility or my spouse's eligibility for coverage and may be used in connection with any claim filed with Pacific Blue Cross. A photocopy of this authorization shall be as valid as the original.

I authorize Pacific Blue Cross or its reinsurers to make a brief report of my personal health information to the Medical Information Bureau.

I acknowledge receipt of written notification describing the use of the Medical Information Bureau.

I, the member, authorize payroll deductions if applicable.

Member's signature **X**	Date (mm-dd-yyyy)

PART 7 — MIB PRE-NOTICE

IMPORTANT: Please read carefully.

MIB is a not-for-profit membership organization of insurance companies, including Blue Cross Life Insurance Company of Canada, which operates an information exchange on behalf of its Members to prevent and detect fraud. You can find further information about MIB by visiting its website at www.mib.com.

Upon receipt of a request, MIB will arrange to disclose to you your personal information MIB has in its file. If required, you may contact MIB to seek a correction of the accuracy of your personal information. MIB's address is: **50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734**. Their phone number is: **(866) 692-6901**.

If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, you understand that MIB, upon request, will supply such company with your personal information in its file. MIB receives personal information about Canadian consumers and the collection, use and disclosure of such personal information is governed by the Personal Information Protection and Electronic Documents Act ("PIPEDA") and provincial laws. MIB has agreed to protect such information in a manner that is substantially similar to the privacy and security practices of MIB's Canadian member companies, and in accordance with applicable laws. As a U.S. based company, MIB is bound by, and such personal information may be disclosed in accordance with, applicable U.S. laws. An individual's consumer file at MIB may be accessible to U.S. law enforcement and U.S. national security authorities for anti-terrorist and clandestine intelligence investigations; provided that such authorities comply with the consumer privacy protections specified in applicable U.S. laws.

Blue Cross Life Insurance Company of Canada may also release your personal information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.