Public Education BENEFITS TRUST
PEBT
Your benefits, your health

Please complete this form should you wish to apply for Optional Accidental Death and Dismemberment coverage and return it to your District Benefits Administrator. The effective date of coverage is the date you are eligible for this coverage or the date you sign this application form, whichever is later.

Optional Accidental Death and Dismemberment Application

Part 1: Employee & Basic Insurance Information

Plan Member/Employee's Last Name	First Name	Initial	Gender	District #
			❑ M – Male ❑ F – Female ❑ X – Another Gender ❑ U – Prefer Not to Disclose	

District ID Number	Birthdate (yyyy/mm/dd	Employee's Occupation/Position

Street Address	City	Province	Postal Code

Amount of Principal Sum (Coverage is available in units of $10,000 to a maximum of $500,000)	Type of Plan
$	❑ Employee Only ❑ Family Plan

Part 2: Beneficiary Designation — Complete the following section to appoint a beneficiary for any benefits payable on your death.

Beneficiary - Last Name	First Name	Initial	Share of Proceeds	Relationship	Name of Trustee for Beneficiaries Under 18
			%		
			%		
			%		
			%		

I consent to the collection, use, and disclosure of my personal information by my Plan Sponsor/Employer or the administrator, an insurance company, or any other person or organization having any relevant information about me (collectively "the Parties") who require this information for the purpose of administering my group benefits under the plan. I authorize the Parties to obtain and exchange between them, any personal information about me, my spouse, and my dependent children for the purpose of determining benefit entitlements, and for record keeping, file identification, reporting, underwriting, procurement of health information, claims adjudication and resolution, program management, administration of the plan and other services provided from time to time.

I confirm that I have obtained consent from my spouse and any dependent children over the age of majority, to disclose their personal information to the Parties as required for the administration of the plan.

In the case of death, I expressly authorize my employer, the policyholder, the beneficiary, heir or liquidator of my estate to provide the Insurance companies, when required by the latter, with all the information and authorizations required for the processing of any claim(s).

I hereby apply for group optional accidental death and dismemberment coverage under my Plan Sponsor's/Employer's plan and authorize any required deductions. I certify that the information given above is true and complete. A photocopy of this authorization is as valid as the original. The original application form will be retained by my Plan Sponsor/Employer.

Plan Member/Employee Signature ______________________________ Date Signed (yyyy/mm/dd) ____________________

District Benefits Administrators - submit completed form to enrollment@pac.bluecross.ca