

Application for STS Group Benefits Program

Member Information (Please Print)

Last Name		First Name (s)			Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Date of Birth Day Month Year	Social Insurance Number		Provincial Medical Plan Number – PMP No. (Health Card)		Teaching Certificate #	
Address – Street			City	Province	Postal Code	
Telephone Number		Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widow/Widower <input type="checkbox"/> Common Law			Title Other <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. _____ <input type="checkbox"/> Miss <input type="checkbox"/> Ms.	
E-mail address						
Date of Retirement		Effective Month of Coverage OR Month you wish coverage to commence				

All information must be received by the 15th of the month in order for coverage to be effective the 1st of the following month, unless medical underwriting is required.

Which pension plan are you a member of

- SK Teachers Retirement Plan SK Teachers Superannuation Plan STF Employees' Pension Plan Other

Plan Information

Extended health plan (Includes hospital coverage) I wish to enrol in this plan: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes indicate: <input type="checkbox"/> Single <input type="checkbox"/> Couple <input type="checkbox"/> Family	Dental Plan I wish to enrol in this plan: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes indicate: <input type="checkbox"/> Single <input type="checkbox"/> Couple <input type="checkbox"/> Family
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If terminating from an employer group benefit plan (spouse or self), please complete.

Employer: _____
 Employee: _____ Date of Termination _____

If you have selected couple or family coverage, please complete the following.

Relationship to Participant	First Name	Last Name	Sex	Date of Birth dd/mm/yyyy	PMP Number	If Child(ren) Over 21 Indicate Student or Handicapped
Spouse						
Dependent Child						
Dependent Child						

If child(ren) over 21,
name of school(s):

I hereby apply for coverage under the STS Group Benefits Program and authorize the deduction and remittance of premiums from my Superannuation Allowance. I consent to disclosure of any information required to administer the program. I authorize the use of my Social Insurance Number for tax reporting, identification and administration of my benefits. I hereby certify that I am a member, in good standing, of STS and my eligibility ceases upon termination of my STS membership.

Signature of Applicant _____ Date _____ Day _____ Month _____ Year _____

Office Use	Effective Retirement Date	Date Retirement Application Received	Date Submitted To Blue Cross
	Date of STS Approval		Processed by STSC/STRP/STF EPP/TCU
	Subject to medical underwriting <input type="checkbox"/> No <input type="checkbox"/> Yes Receipt Date _____ First Payroll Month _____		