

Application for STS Group Benefits Program

Superannuated Teachers of Saskatchewan, 2311 Arlington Avenue, Saskatoon, Saskatchewan S7J 2H8

Information (Please Print)						
Last Name		First Name(s)			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Date of Birth (DAY/MON/YEAR)		Social Insurance Number		Provincial Medical Plan Number PMP No. (Health Card)		Teacher's Certificate Number
Mailing Address			City		Province	Postal Code
Phone		Email Address				
Date of Retirement (DAY/MON/YEAR)		Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Common Law <input type="checkbox"/> Single		<input type="checkbox"/> Please check here if you are a surviving spouse of a deceased superannuate		
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.						
Indicate the Plan from which you receive a pension: <input type="checkbox"/> Saskatchewan Teachers' Retirement Plan <input type="checkbox"/> Saskatchewan Teachers' Superannuation Plan <input type="checkbox"/> STF Employees' Pension Plan <input type="checkbox"/> Other						
Dependent Information						
If you have selected couple or family coverage, please complete the following						
Relationship to Participant	First Name	Last Name	Sex	Date of Birth DAY/MON/YEAR	Provincial Medical Plan No.	If Child(ren) Over 21 Indicate Student or Handicapped
Spouse						
Dependent Child						
Dependent Child						
If child(ren) over 21, name of school(s):						
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			
If terminating from an employer group benefit plan (spouse or self), please complete.						
Employer				Date of Termination (DAY/MON/YEAR)		
Employee						
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/MON/YEAR)		
x						
Office Use – All Dates (DD MMM YYYY)						
Effective Retirement Date		Date Submitted To Blue Cross		Processed by STSC/STRP/STF EPP/TCU		
Date of STS Approval		Receipt Date		First Payroll Month		
Subject to medical underwriting: <input type="checkbox"/> NO <input type="checkbox"/> YES						