Your 2026-2027 British Columbia Employee Benefits Plan page #1

You have an opportunity to select coverage levels under your Group Benefits Plan with The Benefits Trust. Under this plan you have three options to choose from: the Standard plan, the Enhanced plan or Opt-out and exclude yourself from the benefits offered through the plan.

Bi-Weekly employee cost (every 2 week pay cycle) is located below.

Below is a brief summary of the **Standard** and **Enhanced** plans.

Life Insurance, Accidental Death & Dismemberment	**Standard**	**Enhanced**
	Flat amount of **$10,000** Life Insurance and Flat amount of $10,000 AD&D Insurance Benefit reduces by 50% at age 65 Termination age 75 or earlier retirement	Flat amount of **$50,000** Life Insurance and Flat amount of $50,000 AD&D Insurance Benefit reduces by 50% at age 65 Termination age 75 or earlier retirement
Termination Age	75, or earlier retirement	

Extended Health Care	**Standard**	**Enhanced**
Prescription drugs	**90% - to $2,500** annual maximum (per family) of all generic drugs. Dispensing fee employee paid Includes a Pay-direct drug card	**100% - to $7,500** annual maximum (per family) of all generic drugs. Dispensing fee employee paid Includes a Pay-direct drug card
Paramedical Care	**80% to $750** combined annual maximum, per person/per practitioner Includes: Registered Acupuncturist, Chiropodist/Podiatrist, Chiropractor, Naturopath, Osteopath, Physiotherapist, Psychologist, Registered Massage Therapist, Speech Therapist, Dietician, Audiologist, Homeopath, Occupational Therapist, Social Worker	**90% to $1,000** combined annual maximum, per person/per practitioner Includes: Registered Acupuncturist, Chiropodist/Podiatrist, Chiropractor, Naturopath, Osteopath, Physiotherapist, Psychologist, Registered Massage Therapist, Speech Therapist, Dietician, Audiologist, Homeopath, Occupational Therapist, Social Worker
Hospital	90% semi-private room	
Vision Care	100% to a maximum of **$150** every 24 consecutive months for adults, 12 months for children	100% to a maximum of **$200** every 24 consecutive months for adults, 12 months for children
Eye Exam	100% reasonable and customary. Maximum one eye exam every 24 consecutive months for adults, 12 months for children	

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Aids and Appliances	**80%** coverage Hearing aids: to a maximum of $500/every 4 years **Orthotics/Orthopedic shoes**: to a maximum of $300/per year	**90%** coverage Hearing aids: to a maximum of $500/every 4 years **Orthotics/Orthopedic shoes**: to a maximum of $300/per year
Out of Country Emergency Medical	**100% Out of Country emergency medical coverage**, lifetime maximum $5,000,000 per insured. Up to 30days per trip for business or vacation	
Termination Age	75, or earlier retirement	

Dental Care	**Standard**	**Enhanced**
	80% to **$1,500** combined overall max per person/per benefit year Basic, Preventative, Endodontic and Periodontal services (Level I, Level II) Recalls every **9 months** Current Dental Association Fee Guide for General Practitioners No Major Restorative	80% to **$2,000** combined overall max per person/per benefit year Basic, Preventative, Endodontic, Periodontal & **Major Restorative services** (Level I, Level II and Level III) Recalls every **6 months** Current Dental Association Fee Guide for General Practitioners 50% **Major Restorative** coverage
Termination Age	75, or earlier retirement	

Bi-Weekly Cost (every 2 week pay cycle)

	Standard		**Enhanced**	
Life, AD&D	$2.39		$11.96	
Extended Healthcare & Dental	**Single** $52.33	**Family** $129.58	**Single** $85.27	**Family** $196.94

Employee Benefits Enrollment Form

the benefits trust

Part A: Employee to complete in ink

Personal Information

☐ Mr. ☐ Mrs.
☐ Ms. ☐ Miss

Last Name: _____ First Name: _____

Address: _____ Apt. # _____

City: _____ Province: _____ Postal Code: _____

Date of Birth: (Month) _____ (Day) _____ (Year) _____ S.I.N. : _____ - _____ - _____

Sex: ☐ M ☐ F ☐ ☐

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Common Law Length of C/L Relationship: _____

Dependant Information

Please list all dependants including your spouse, common-law spouse (relationship of at least one year), and/or children. Refer to your benefits booklet or ask your employer to confirm who is considered an eligible dependant. Complete an "**Overage Dependant**" form if applicable.

			Date of Birth (Month) / (Day) / (Year)
Spouse's Last Name	First Name		
_____	_____	☐ M ☐ F	_____ / _____ / _____
Child's Last Name	First Name		
1. _____	_____	☐ M ☐ F	_____ / _____ / _____
2. _____	_____	☐ M ☐ F	_____ / _____ / _____
3. _____	_____	☐ M ☐ F	_____ / _____ / _____
4. _____	_____	☐ M ☐ F	_____ / _____ / _____

Does your **spouse** have benefits coverage through his/her employer's plan? ☐ No ☐ Yes. If Yes: ☐ Single ☐ Family

Selection of Coverage

Please indicate Single coverage (for yourself only), Family coverage (for yourself and your dependants), or Waived (no coverage for yourself and no coverage for your dependants).

Health and Dental Benefits: ☐ Standard ☐ Enhanced ☐ Waived/Opt-out

Type of Coverage: ☐ Single ☐ Family

Life & AD&D Insurance: ☐ Standard ☐ Enhanced ☐ Waived/Opt-out

Revocable Beneficiary Designation

If your beneficiary is a child under age 18, you must also complete a "**Declaration Appointing Trustee**" form. If you make any changes or corrections in this section, you must initial the change or correction.

Beneficiary's Last Name	First Name	Relationship (e.g. spouse, child)	Age (If a child)
_____	_____	_____	_____

For Quebec residents: the appointment of a spouse as Beneficiary is considered "IRREVOCABLE" unless the word "REVOCABLE" is written after the spouse's name.

Employee Authorization

I hereby apply for the benefits for which I am or may become eligible, subject to any waiver indicated, under the Benefit Services Contract issued by The Benefits Trust and authorize that any required contributions be deducted from my earnings. In addition, I authorize The Benefits Trust and its administrators to use my social insurance number, if applicable, for identification purposes in the administration of the Benefit Services Contract. On behalf of myself and my dependents, I also authorize The Benefits Trust (including its affiliates and/or insurance partners) to exchange the information detailed in this Enrollment and any other benefit related information contained in files regarding me or my dependents, now or in the future, for the purposes of administration and/or management of the Benefit Services Contract issued by The Benefits Trust.

Employee Signature: _____ Date: (Month) _____ (Day) _____ (Year) _____