ARTA
BENEFIT PLANS

Application for Health and Dental Plans
PUBLIC / PRIVATE SECTOR

INSTRUCTIONS

1. Complete this enrolment form and return it to ARTA's head office by mail, fax, or email as indicated.
2. This plan does not take effect until the required information is deemed complete and accurate.
3. For questions regarding the ARTA Benefit Plans, please contact the ARTA Member Services at **info@arta.net**, 780-822-2400 (Edmonton) or 1-855-212-2400.

1. PLAN MEMBER INFORMATION (Please print legibly)

NAME First Name _____ Last Name _____ **GENDER** ○ F ○ M

MAILING ADDRESS _____

CITY/TOWN _____ **PROVINCE** _____ **POSTAL CODE** _____

PHONE _____ **EMAIL** _____

BIRTH DATE _____ Month/Day/Year

Your ARTA Benefits Plan information and ID card will be sent to you by email. If you wish to receive them by mail instead, please check here. ☐

To participate in this plan, you must be enrolled in all provincial or territorial health care plans for which you are eligible
(Example: Alberta Health Care, Alberta Coverage for Seniors if you or your spouse are age 65 or over, or the BC Fair PharmaCare plan).

Public/Private sector plan participation:

○ ACAO	○ ACPA	○ Alberta Doctors
○ AIA	○ AIC	○ AMSC/AUMA
○ APSC	○ ASET	○ ATB
○ ATU	○ Capital Care	○ CFD
○ CHAPA	○ CPA AB	○ CSU 52
○ CTTAM	○ CUDGC	○ CUPE
○ HBTA	○ HSAA	○ LAPP
○ LRHF	○ MEPP	○ MLA
○ NEBS	○ PSPP	○ RECA
○ SAFA	○ Servus	○ SFPP
○ TPS	○ UNA	○ Covenant Health

○ Judges & Masters in Chambers
○ MNP (or acquired company)

Date of Membership in the above noted association/ organization/group

_____ Month/Day/Year

IMPORTANT: When transferring from an employer-sponsored group insurance plan ***OR* your spouse's employer-sponsored group insurance plan, you ***MUST*** provide the following information, ***INCLUDING*** termination dates. Coverage is effective the day after your or your spouse's plan terminates.**

INSURANCE COMPANY _____

POLICY/ID NUMBER _____

Termination date of *your* group benefits plan or *your spouse's* plan

GROUP EXTENDED HEALTH CARE PLAN _____ Month/Day/Year

GROUP DENTAL PLAN _____ Month/Day/Year

ARTA BENEFIT PLANS

SEND FORMS TO

ARTA Head Office
15505 137 Avenue NW, Edmonton, AB T5V 1R9

EMAIL: info@arta.net

Please ensure all information is correct, failure to do so may delay processing your application. ARTA acknowledges all applications to the Benefit Plans received by email or the postal service. If you have not heard from us within five business days, please contact us at 1-855-444-ARTA (2782).

2. PLAN SELECTION

NOTE: you are able to move up in coverage at anytime, however you are locked in for 24 months once you have increased your coverage

Under Age 65 Plan Options

Please refer to the provided plan summary and rate sheets for descriptions of each plan.

I wish to enrol in this plan:

◯ **Yes** ◯ **No**

If yes, please select your Health Plan Option

Health and Dental Plan Option

Select One

◯ **Primary Health** ◯ **Core Health**
◯ **Essential Health** ◯ **Enhanced Health**

Dependant Coverage

Select One

◯ **Single** (you alone) ◯ **Couple** (you and one other eligible dependant)
◯ **Family** (you and two or more eligible dependants)

Build-Your-Own Plan Options

EXTENDED HEALTH CARE PLAN

I wish to enrol in this plan:

◯ **Yes** ◯ **No**

If yes, please complete below.

Health Plan Option

Select One

Travel included
◯ **Total Health™**
◯ **Ultimate Health™**
◯ **ARTARx + Travel™**

Travel ***NOT*** included
◯ **Health Wise™**
◯ **Health Wise Plus™**
◯ **ARTARx**

Prescription Drug Option

Select One **(Not required if you selected an ARTARx Plan above)**

◯ **$1,200** Annual Maximum ◯ **$2,000** Annual Maximum

Dependant Coverage

Select One

◯ **Single** (you alone)
◯ **Couple** (you and one other eligible dependant)
◯ **Family** (you and two or more eligible dependants)

DENTAL CARE PLAN

I wish to enrol in this plan:

◯ **Yes** ◯ **No**

If yes, please complete below.

Dental Option

Select One

◯ **Option A** (80% Basic and Minor, 50% Major)
◯ **Option B** (80% Basic and Minor)
◯ **Option C** (65% Basic and Minor)

Dependant Coverage

Select One

◯ **Single** (you alone)
◯ **Couple** (you and one other eligible dependant)
◯ **Family** (you and two or more eligible dependants)

By choosing a dental care plan, you are committed to participate for a minimum duration of 24 months.

If you have selected **Couple** or **Family** coverage in either the Under Age 65 or Build-Your-Own Plan options above, please complete the following.

SPOUSE

NAME ________ First Name ________ Last Name GENDER ◯ F ◯ M BIRTH DATE ________ Month/Day/Year

DEPENDANT CHILD

NAME ________ First Name ________ Last Name GENDER ◯ F ◯ M BIRTH DATE ________ Month/Day/Year

Children over 21 must be a student or disabled; proof of disability or student status is required. ◯ Student ◯ Disabled

DEPENDANT CHILD

NAME ________ First Name ________ Last Name GENDER ◯ F ◯ M BIRTH DATE ________ Month/Day/Year

Children over 21 must be a student or disabled; proof of disability or student status is required. ◯ Student ◯ Disabled

DEPENDANT CHILD

NAME ________ First Name ________ Last Name GENDER ◯ F ◯ M BIRTH DATE ________ Month/Day/Year

Children over 21 must be a student or disabled; proof of disability or student status is required. ◯ Student ◯ Disabled

3. PERSONAL PRE-AUTHORIZED DEBIT AGREEMENT

I authorize the Alberta Retired Teachers' Association (ARTA) to begin monthly automated withdrawals for payment of my benefit premiums and ARTA membership fees from the bank account identified. I understand that the following conditions apply:

a) ARTA may only assign this Personal Pre-authorized Debit Agreement ("PAD Agreement") to the Third Party Administrator contracted to administer the ARTA Benefit Plans;

b) I will pay the monthly premium and ARTA membership fee amount noted in my approval letter and a monthly statement will not be issued;

c) I will receive at least 10 days prior notification of changes in the monthly amount payable due to:
- Premium rate adjustments, which typically occur in November, and
- A change in benefit coverage

d) My monthly premium payment and ARTA membership fees will automatically be withdrawn from my bank account on the 10th of the month. If the 10th falls on a weekend or holiday, the withdrawal will occur on the next business day;

e) Premiums and ARTA membership fees are billed in complete months and if my benefits terminate prior to the last day of the month, I will remain responsible for the full month's premium and membership fee;

f) If there is a change in coverage that takes effect part way through a month (e.g. a change from "family" to "single" status), coverage will begin as of the date of the change. On the first day of the following month, the new premium will be charged; and

g) I will notify the Administrator of any changes to my banking information.

My authorization will remain in effect until there is 30 days written notification of termination from either myself or from ARTA. To obtain a sample cancellation form, or for more information on my right to cancel this PAD Agreement, I may contact my financial institution or visit **cdnpay.ca**.

If the Administrator makes a withdrawal in error or for the incorrect amount, I will notify the Administrator as soon as possible. If the Administrator is aware of an error, the error will be corrected and I will be notified as soon as possible.

I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit **cdnpay.ca**.

Non-Payment of Premiums

If my benefits are terminated due to non-payment of premiums, coverage will end and I will not be able to re-enrol in benefits until I make restitution, which may include payment of premiums, interest, non-sufficient fund charges and claims paid after termination. **I understand that ARTA retains the right to deny re-enrolment should coverage be terminated due to non-payment of premiums.**

It is understood that I must be an ARTA member to access the ARTA Benefit Plans. **Non-payment of ARTA membership fees will result in my ARTA benefits coverage being terminated**.

If you have any questions about this PAD Agreement, please contact a Member Services Administrator at:

Phone: 780-822-2400 (in the Edmonton area)
Toll-free: 1-855-212-2400
Email: **info@arta.net**

4. AUTOMATIC DIRECT DEPOSIT

Automatic direct deposit will be used for benefit claims payments and approved refund of premium payments. Direct deposit ensures that payment is made directly into your bank account and provides:

- faster and safer service than mailing a cheque to you
- protection from delays during postal service disruptions
- automatic deposits to your bank account if you are away from home

Most financial institutions participate in direct deposit. You should check with your financial institution to make sure it can receive payment into your desired account. The financial institution's personnel will help you complete this form if necessary.

Claim deposits will be made to the same bank account unless a *void cheque* from a separate bank account is attached.

5. AUTOMATIC DIRECT WITHDRAWAL

Banking Information

Attach a void cheque marked "withdrawals", direct deposit bank note, or proof of account ownership from your bank.

Attach void cheque here:

PAYOR NAME First Name Last Name

RELATIONSHIP TO APPLICANT (If payor is different from applicant) **DATE** Month/Day/Year

PAYOR ADDRESS

CITY/TOWN **PROVINCE** **POSTAL CODE**

Signature (confirms acceptance of the terms of the PAD agreement; original signature — do not type name)

6. CONSENT (Please check all boxes – required)

- ☐ I hereby apply for ARTA membership and coverage under the ARTA Benefit Plans as indicated herein.
- ☐ ARTA requires the personal information contained herein in order to administer the benefits plan. It may be necessary for ARTA to disclose some or all of the personal information contained herein to third party service providers for these purposes. Where third party service providers are retained, appropriate contracts are in place to protect personal information.
- ☐ I understand why the information is required and am aware of the risks and benefits of providing this information. I consent to the collection, use, and disclosure of my personal information for the purposes identified above. I understand that I may revoke my consent at any time and acknowledge that doing so will affect my and my dependants' eligibility to receive benefits.
- ☐ I understand that by virtue of the provisions of the *Personal Information Protection Act* of Alberta, my dependants are deemed to consent to the collection, use, and disclosure of their personal information for the purpose of enrolment in and coverage under the group benefit plans, through me as the applicant.
- ☐ I understand that I meet all the eligibility requirements listed on the applicable plan summary and rate sheet.
- ☐ I agree to allow the Alberta Retired Teachers' Association to contact me by email regarding my benefit plan, ongoing advocacy efforts, monthly ARTAfacts e-newsletter, and any special news and events. I may withdraw my consent at any time using the link at the bottom of the email communications from ARTA.
- ☐ I understand that by choosing to participate in a Build-Your-Own Dental plan I am committing to participate for a minimum duration of 24 months.

How did you hear about ARTA?

- ☐ **HR Department**
- ☐ **Convention/Trade Show**
- ☐ **Advertising**
- ☐ **Website**
- ☐ **Google/Search**
- ☐ **ARTA Presentation**
- ☐ **Friend/Family member**

(member name)

- ☐ **Other**

(please specify)

7. SIGNATURE

DATE

Signature of Applicant (original signature – do not type name) Month/Day/Year

SAVE FORM