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 on the last page.
2. This plan does not take effect until the required information is complete and accurate.
3. For questions regarding the ARTA Retiree Benefits Plan, please contact the ARTA Member Support Centre at **info@arta.net**, 780-822-2400 (Edmonton) or 1-855-212-2400.

1. Plan Member Information (Please print legibly)

NAME _____ _____ GENDER ☐ F ☐ M
First Name Last Name

MAILING ADDRESS _____

CITY/TOWN _____ PROVINCE _____ POSTAL CODE _____

PHONE _____ CELL PHONE _____ EMAIL _____

BIRTH DATE _____
Year/Month/Day

Your ARTA Retiree Benefits Plan information and Member ID card will be sent to you by email and can be found on the MyARTA website (myarta.net). 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	☐ APSC
☐ ATB	☐ ATU	☐ Capital Care
☐ CFD	☐ CHAPA	☐ CPA AB
☐ CSU 52	☐ CUDGC	☐ CUPE
☐ LAPP	☐ LRHF	☐ MEPP
☐ MLA	☐ NEBS	☐ PSPP
☐ RECA	☐ SAFA	☐ SFPP
☐ UNA	☐ Judges & Masters in Chambers	

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

_____
Year/Month/Day

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 _____
Year/Month/Day

GROUP DENTAL PLAN _____
Year/Month/Day

OFFICE USE ONLY

CODE _____ ARTA MEMBERSHIP # _____

ARTA DATE STAMP(S) COMMENTS

2. Plan Selection (Please refer to the provided plan summary for descriptions of each plan)

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™**

Travel ***NOT*** included
- ☐ **Health Wise™**
- ☐ **Health Wise Plus™**

Prescription Drug Option
Select One

☐ **$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)

If you have selected **Couple** or **Family** coverage, please complete the following:

SPOUSE

NAME ______ ______ GENDER ☐ ☐ BIRTH DATE ______
First Name Last Name F M Year/Month/Day

DEPENDANT CHILD

NAME ______ ______ GENDER ☐ ☐ BIRTH DATE ______
First Name Last Name F M Year/Month/Day

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

DEPENDANT CHILD

NAME ______ ______ GENDER ☐ ☐ BIRTH DATE ______
First Name Last Name F M Year/Month/Day

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

DEPENDANT CHILD

NAME ______ ______ GENDER ☐ ☐ BIRTH DATE ______
First Name Last Name F M Year/Month/Day

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 assign this Personal Pre-authorized Debit Agreement ("PAD Agreement") to administer the ARTA Retiree Benefits Plan;

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 (I have waived my right to receive pre-notification of the amount of the PAD and agree that I do not require advance notice of the amount of PADs before the monthly debit is processed.);

c) I will receive at least ten 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 tenth of the month. If the tenth 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 inform ARTA of any changes to my banking information.

My authorization will remain in effect until there is thirty 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 ARTA makes a withdrawal in error or for the incorrect amount, I will notify ARTA as soon as possible. If ARTA 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 Retiree Benefits Plan. **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 the Member Support team at:

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

4. Automatic Direct Withdrawal

Banking Information

Attach a void cheque marked "withdrawals" 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** Year/Month/Day

PAYOR ADDRESS

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

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

5. 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.

6. Consent (Please check all boxes – required)

☐ I hereby apply for ARTA membership and coverage under the ARTA Retiree Benefits Plan 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 agree to allow the Alberta Retired Teachers' Association to contact me by email regarding my Retiree Benefits 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.

How did you hear about ARTA?

☐ **HR Department**

☐ **Convention/Trade Show**

☐ **Advertising**

☐ **Website**

☐ **Google/Search**

☐ **Friend/Family member**

(member name)

☐ **Other**

(please specify)

7. Signature

DATE

Signature of Applicant (original signature – do not type name)

Year/Month/Day

Please ensure all information is correct, failure to do so may delay processing your application.

SAVE FORM

ARTA RETIREE BENEFITS PLAN

SEND FORMS TO

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

FAX: 780-447-0613 **EMAIL:** info@arta.net

Sponsored by

ARTA
ALBERTA RETIRED TEACHERS' ASSOCIATION