ARTA
BENEFIT PLANS

Health, Dental, and Travel Plan
CHANGE APPLICATION FORM

INSTRUCTIONS

1. Complete the section(s) below which are applicable to your change. Send your completed form to ARTA's Member Support Centre, using the contact methods provided on page 3 of this document.
2. You should keep a copy of the completed form for your records.
3. To make other changes not covered in this form (e.g., change your address, date of birth, add/remove reference to another benefit plan) or if you have any questions, please visit **myarta.net**.

1. PLAN MEMBER INFORMATION (Please print legibly)

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

MAILING ADDRESS _____

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

PHONE _____ **EMAIL** _____

ARTA BENEFITS ID NUMBER _____ **BIRTH DATE** _____
(eg. ART12345-00) Month/Day/Year

What type of change would you like to make?

- ☐ Dependant change(s), complete Section 2, including dependant information
- ☐ Health and/or Dental Plan change(s), complete Section 3
- ☐ Supplementary Travel Insurance, complete Section 4

2. DEPENDANT CHANGE

Please check off the event prompting the change in your benefits:

- ○ Marriage/Common Law ○ Separation ○ Divorce/Loss of Spouse
- ○ Birth/Adoption/Guardianship: (please provide a copy of the legal guardianship papers)
- ○ Loss of spousal/partner's coverage: **Insurance Company** _____
  Policy Number _____
- ○ Other: _____

DATE OF ABOVE EVENT _____
Month/Day/Year

COMPLETE THE BELOW INFORMATION IF YOU ARE ADDING A NEW DEPENDANT.

SPOUSE — GENDER — Date of Birth — Valid Prov. Health Plan #

First Name | Last Name | F | M | Month/Day/Year | Yes | No

DEPENDANT CHILD — GENDER — Date of Birth — Valid Prov. Health Plan #

First Name | Last Name | F | M | Month/Day/Year | Yes | No

Child(ren) over 21 must be a student or disabled ***(if disabled, proof of disability may be required)*** ○ Student ○ Disabled

DEPENDANT CHILD — GENDER — Date of Birth — Valid Prov. Health Plan #

First Name | Last Name | F | M | Month/Day/Year | Yes | No

Child(ren) over 21 must be a student or disabled ***(if disabled, proof of disability may be required)*** ○ Student ○ Disabled

DEPENDANT CHILD — GENDER — Date of Birth — Valid Prov. Health Plan #

First Name | Last Name | F | M | Month/Day/Year | Yes | No

Child(ren) over 21 must be a student or disabled ***(if disabled, proof of disability may be required)*** ○ Student ○ Disabled

Note: Dependants added after sixty days from the date of the life event are considered late applicants and restriction may apply.

3. HEALTH AND/OR DENTAL PLAN CHANGE(S)

DATE OF COVERAGE CHANGE

Month/Day/Year

*** Comprehensive Benefit Plans available starting Nov. 1, 2021.**
**** ARTARx Benefit Plans available starting January 1, 2022**

BENEFIT OPTIONS	REQUESTED COVERAGE *** see limitations below
Comprehensive Benefit Plans*	○ Primary Health ○ Core Health ○ Essential Health ○ Enhanced Health
Build-Your-Own Plan Option	**With Travel**: ○ Total Health ○ ARTARx + Travel** ○ Ultimate Health **Without Travel**: ○ Health Wise ○ ARTARx** ○ Health Wise Plus
Prescription Drug Option *Complete this section if you chose Health Wise, Health Wise Plus, Total Health or Ultimate Health*	○ $1,200 annual drug limit ○ $2,000 annual drug limit
Health Plan Dependant Coverage	○ Single *(you)* ○ Couple *(you and one (1) other person)* ○ Family *(you and two (2) or more people)*
Dental Option *You do not need to complete the dental option section if you chose a Comprehensive Benefit Plan*	○ Option A *(80% Basic and minor, 50% Major)* ○ Option B *(80% Basic and minor)* ○ Option C *(65% Basic and minor)*
Dental Dependant Coverage	○ Single *(you)* ○ Couple *(you and one (1) other person)* ○ Family *(you and two (2) or more people)*

Coverage Change Limitations***

Annual Drug Limit: If you select the $2,000 annual drug limit option, you are required to remain covered at this level for a minimum period of 24 months from the effective date of coverage before lowering your annual drug limit option to $1,200.

Health Plan Option: If you choose to participate in either the Health Wise Plus or Ultimate Health plans, you are required to remain covered at that coverage level for a minimum period of 24 months from the effective date of coverage before reducing your coverage to either the Health Wise or Total Health coverage options.

Dental Option: Please note that you must be enrolled in Option A, B, or C, for a period of 24 months before you are able to cancel or reduce your coverage option.

Adding Travel: If you are adding base travel coverage after 60 days from the eligibility date, you are considered a late applicant. Please complete a Declaration of Insurability form for each applicant. Forms are available by contacting ARTA.

Adding Dental: If you are adding Dental coverage after 60 days from the eligibility date, you are considered a late applicant. As a late applicant, your maximum amount of benefit payable for minor and major restorative services is prorated from the date your application is received to December 31st of your first calendar year of coverage. After December 31st of your first calendar year of coverage, the annual maximum payable will be as specified in the benefits plan summary.

Other Benefits: If you would like to add Life Insurance, please contact the Member Support team at 1-855-212-2400 for information.

4. SUPPLEMENTARY TRAVEL INSURANCE

WHAT WOULD YOU LIKE TO DO?

1) Add Coverage ○ Single ○ Couple ○ Family

2) ☐ **Update Travel Dates**

DEPARTURE DATE	RETURN DATE
Month/Day/Year	Month/Day/Year

Total Number of Days

3) ☐ **Terminate Supplementary Travel Coverage**
Proof of departure and return is required for termination requests received after departure date, e.g., receipt, passport stamp, etc. with your name, date, and location indicated.

DATE OF TERMINATION

Month/Day/Year

5. CONSENT (Please check all boxes – required)

The Alberta Retired Teachers' Association (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 benefits plan, through me as the applicant.

6. SIGNATURE

DATE

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

Month/Day/Year

SAVE FORM

ARTA RETIREE 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 Retiree 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).