Application for STS Group Benefits Program

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

Member Information (Please Print)

Last Name | First Name(s) | Gender ❑ Male ❑ Female

Date of Birth (DD MMM YYYY) | 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 (DD MMM YYYY)

Marital Status ❑ Married ❑ Common Law ❑ Single

❑ 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.

Which pension plan are you a member of:

❑ Saskatchewan Teachers' Retirement Plan ❑ Saskatchewan Teachers' Superannuation Plan ❑ STF Employees' Pension Plan ❑ 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 DD MMM YYYY	PMP Number	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: ❑ Yes ❑ No

If yes indicate: ❑ Single ❑ Couple ❑ Family

Dental Plan

I wish to enrol in this plan: ❑ Yes ❑ No

If yes indicate: ❑ Single ❑ Couple ❑ Family

If terminating from an employer group benefit plan (spouse or self), please complete.

Employer

Employee | Date of Termination (DD MMM YYYY)

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 (DD MMM YYYY)

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: ❑ NO ❑ YES