Optional Group Life Insurance Plan

- Employees actively employed at half-time or more and who are already enrolled in the Basic Group Life Insurance are eligible to enroll in the Optional Group Life Insurance plan.

- The optional life insurance is available in units of $25,000 (minimum $25,000, maximum $500,000). The amount of accidental death and dismemberment insurance will be limited to the amount of your optional life insurance selected.

- If applying for coverage ensure all forms in the package are completed (enrolment form, authorization and application) and signed.

University of Victoria #40703
Optional Group Life Insurance Monthly Premium
Employee and Spouse (note: Spouse rate based on Employee Age)

ns = non-smoker, s = smoker

July 1, 2021 RENEWAL

$	to age 34		age 35-39		age 40-44		age 45-49		age 50-54		age 55-59		age 60-64		age 65-69		age 70	
	ns	s	ns	s	ns	s	ns	s	ns	s	ns	s	ns	s	ns	s	ns	s
25,000	0.48	1.00	0.70	1.25	0.93	1.88	1.70	3.48	3.38	6.85	5.85	11.95	10.38	20.65	15.70	31.53	21.58	43.08
50,000	0.95	2.00	1.40	2.50	1.85	3.75	3.40	6.95	6.75	13.70	11.70	23.90	20.75	41.30	31.40	63.05	43.15	86.15
75,000	1.43	3.00	2.10	3.75	2.78	5.63	5.10	10.43	10.13	20.55	17.55	35.85	31.13	61.95	47.10	94.58	64.73	129.23
100,000	1.90	4.00	2.80	5.00	3.70	7.50	6.80	13.90	13.50	27.40	23.40	47.80	41.50	82.60	62.80	126.10	86.30	172.30
125,000	2.38	5.00	3.50	6.25	4.63	9.38	8.50	17.38	16.88	34.25	29.25	59.75	51.88	103.25	78.50	157.63	107.88	215.38
150,000	2.85	6.00	4.20	7.50	5.55	11.25	10.20	20.85	20.25	41.10	35.10	71.70	62.25	123.90	94.20	189.15	129.45	258.45
175,000	3.33	7.00	4.90	8.75	6.48	13.13	11.90	24.33	23.63	47.95	40.95	83.65	72.63	144.55	109.90	220.68	151.03	301.53
200,000	3.80	8.00	5.60	10.00	7.40	15.00	13.60	27.80	27.00	54.80	46.80	95.60	83.00	165.20	125.60	252.20	172.60	344.60
225,000	4.28	9.00	6.30	11.25	8.33	16.88	15.30	31.28	30.38	61.65	52.65	107.55	93.38	185.85	141.30	283.73	194.18	387.68
250,000	4.75	10.00	7.00	12.50	9.25	18.75	17.00	34.75	33.75	68.50	58.50	119.50	103.75	206.50	157.00	315.25	215.75	430.75
275,000	5.23	11.00	7.70	13.75	10.18	20.63	18.70	38.23	37.13	75.35	64.35	131.45	114.13	227.15	172.70	346.78	237.33	473.83
300,000	5.70	12.00	8.40	15.00	11.10	22.50	20.40	41.70	40.50	82.20	70.20	143.40	124.50	247.80	188.40	378.30	258.90	516.90
325,000	6.18	13.00	9.10	16.25	12.03	24.38	22.10	45.18	43.88	89.05	76.05	155.35	134.88	268.45	204.10	409.83	280.48	559.98
350,000	6.65	14.00	9.80	17.50	12.95	26.25	23.80	48.65	47.25	95.90	81.90	167.30	145.25	289.10	219.80	441.35	302.05	603.05
375,000	7.13	15.00	10.50	18.75	13.88	28.13	25.50	52.13	50.63	102.75	87.75	179.25	155.63	309.75	235.50	472.88	323.63	646.13
400,000	7.60	16.00	11.20	20.00	14.80	30.00	27.20	55.60	54.00	109.60	93.60	191.20	166.00	330.40	251.20	504.40	345.20	689.20
425,000	8.08	17.00	11.90	21.25	15.73	31.88	28.90	59.08	57.38	116.45	99.45	203.15	176.38	351.05	266.90	535.93	366.78	732.28
450,000	8.55	18.00	12.60	22.50	16.65	33.75	30.60	62.55	60.75	123.30	105.30	215.10	186.75	371.70	282.60	567.45	388.35	775.35
475,000	9.03	19.00	13.30	23.75	17.58	35.63	32.30	66.03	64.13	130.15	111.15	227.05	197.13	392.35	298.30	598.98	409.93	818.43
500,000	9.50	20.00	14.00	25.00	18.50	37.50	34.00	69.50	67.50	137.00	117.00	239.00	207.50	413.00	314.00	630.50	431.50	861.50

Optional Group Accidental Death and Dismemberment Inusrance Monthly Premium

Coverage	25,000	50,000	75,000	100,000	125,000	150,000	175,000	200,000	225,000	250,000
Monthly Premium	.75	1.50	2.25	3.00	3.75	4.50	5.25	6.00	6.75	7.50

To: ***Human Resources***
University of Victoria

For coverage, please complete the enrolment form on the reverse side and forward

Termination of Insurance

Your insurance will cease on the earliest of the following events:

- the date your employment is terminated
- your normal or deferred retirement date, to age 71
- the last day of the last month for which a premium has been paid, subject to the total disability provisions of the group policy
- the date the group policy is terminated

The insurance on your spouse and dependent child will cease on the earliest of the following events:

- the date your employment is terminated
- the date the dependent ceases to qualify under the definition of dependent
- your normal or deferred retirement date, to age 71
- the last day of the last month for which a premium has been paid for your dependent insurance, subject to the total disability provisions of the group policy
- the date the group policy is terminated

Conversion Privilege

If your insurance terminates or reduces for any reason other than solely as a result of your request, you are entitled to a conversion privilege which entitles you to purchase an individual life policy from Blue Cross Life Insurance Company of Canada without undergoing any medical examination. A conversion privilege is also available to your spouse. Conversion privilege is only available up to the normal retirement date.

Making a Claim

If you or any of your insured dependents die, a claim should be made as soon as reasonably possible.

If you become totally disabled or suffer any other loss, a claim should be made not later than 12 months after the onset of the Total Disability or the date of loss.

General Information

This plan provides for premium payment through convenient payroll deduction. The premium you pay is competitive since the insurance is offered on a group basis.

Premium rate changes due to a change between age brackets will occur on your birthday.

This brochure is for information purposes only. Coverage under the plan is governed by the terms of the Optional Group Insurance policy issued by British Columbia Life & Casualty Company.

0034.005 60-15-510 09/15 CUPE 1816

Optional Group Life Insurance Plans

for eligible UVIC faculty and staff

University of Victoria

Underwritten by
BC Life & Casualty Company

Optional Group Life Insurance Plan

This plan provides you with an opportunity to purchase optional group life insurance additional to your basic group life coverage. This insurance is payable in the event of your death from any cause while in the University's employment other than from suicide within two years from the effective date of your insurance.

Optional Group Accidental Death and Dismemberment (AD&D)

This Plan provides you with an opportunity to purchase optional AD&D insurance along with optional group life coverage. This insurance is payable in the event of your accidental death or dismemberment.

Loss of life	*100%*
Loss of both arms or legs	*100%*
Loss of use of one arm or one leg	*75%*
Loss of both hands or both feet	*100%*
Loss of one hand or one foots	*66 2/3%*
Loss of use of one hand or one foot	*66 2/3%*
Loss of entire sight in both eyes	*100%*
Loss of speech	*50%*
Loss of hearing in both ears	*50%*

For example, if, while insured, you sustain accidental bodily injury which results directly and independently of all other causes in one of the losses listed below within 365 days after the injury, BC Life & Casualty Company will pay a benefit as follows (partial list). A schedule of available coverage and the corresponding premium you pay appears below.

No more than 100% of the amount of Optional Group AD&D is payable for all losses due to any one accident.

There are exclusions for which a benefit is not paid relating to suicide, drug overdose, specific aircraft hazards and hostile actions of any armed forces.

Spouse Optional Group Life Insurance Plan

This plan provides you with an opportunity to purchase optional group life insurance for your spouse on the same terms as applicable to you.

A person will qualify as a spouse by virtue of a legal marriage or by being publicly represented as your spouse for a period of at least one year.

This insurance is payable in the event of the death of your spouse from any cause while your coverage remains in force, other than from suicide within two years from the effective date of the insurance.

Amount of Coverage Available

The insurance is available in units of $25,000 (minimum $25,000, maximum $500,000). A schedule of available coverage and the corresponding premium you pay appears below. The amount of accidental death and dismemberment insurance will be limited to the amount of your optional life insurance selected. The additional premium for this benefit also appears below.

Dependent Child Group Life Insurance

$5,000 of child coverage for each eligible dependent child from birth to age 21 (age 25 if a full-time student) will be automatically provided at no extra charge when either employee or spouse optional life insurance is elected. A handicapped child who attains the limiting age may continue coverage as a Dependent if proof of the handicap is received within 31 days after the child attains the limiting age.

This insurance is payable in the event of the death of your dependent child from any cause while coverage is in force, other than from suicide within two years from the effective date of the insurance.

Joining the Plan

You are eligible to join this plan if you are enrolled in the University's basic life insurance program.

New employees and/or their spouses may join the plan subject to providing evidence of insurability satisfactory to BC Life & Casualty Company. Coverage will take effect on the date of approval of the evidence provided you are actively at work. Dependent coverage will take effect on the date of approval of the evidence, provided the dependent is not confined in a hospital or similar institution on that date and you are actively at work.

The Completed Enrolment Form and Health Questionnaire Must Be Forwarded to Human Resources.

When you and/or your spouse enrol you must name the beneficiary to whom benefits would be payable. You may change the beneficiary at anytime subject to any legal restriction which may affect this right by filing a change of beneficiary form with Human Resources. If there is no named living beneficiary, benefits would be paid to your Estate. If children are covered, their benefit will be paid to you, if living, otherwise to your estate.

Changes

Evidence of insurability satisfactory to BC Life & Casualty Company will be required for any increase or addition.

You may increase your employee and/or your spouse's life insurance or your AD&D coverage at any time up to the allowable limit if you and/or your spouse provide evidence of insurability satisfactory to BC Life & Casualty Company.

You may decrease your insurance coverage at any time.

A change in coverage becomes effective on the date evidence of insurability is approved by BC Life & Casualty Company. (Evidence of Insurability forms are available from Human Resources.) In addition, if you are not actively at work on the effective date of change in coverage, you and/or your Dependent's coverage is delayed until you are actively at work. Similarly, Dependent insurance is delayed until discharge for a Dependent who is in a hospital or similar institution.

All changes are subject to the maximum available coverage under this policy.

Total Disability

If you become totally disabled while covered by the plan and before attaining normal or earlier retirement, you and/or your dependent's optional life insurance coverage will remain in force without payment of premium as long as you continue to be totally disabled and provided proof of total disability is furnished as required by BC Life & Casualty Company. The insurance company may also require proof of age.

UNIVERSITY OF VICTORIA BC Life Policy
Employees' and Spouses' Optional Group Insurance **ENROLMENT FORM**

EMPLOYEE family name, first name, initials | ID Number | Date of Birth: Day / Month / Year

SPOUSE family name, first name, initials (if spouse insurance is applied for) | Date of Birth: Day / Month / Year

Have you or your spouse used tobacco products during the 12 month period immediately preceding the date written below beside your signature? Employee ☐ Yes ☐ No Spouse ☐ Yes ☐ No

I apply for Optional Life Insurance for – myself in the amount of $ ____ Multiples of $25,000 to $500,000 ☐ Smoker. ☐ Non Smoker. FOR OFFICE USE ONLY

I apply for Optional Spouse Life Insurance – for my Spouse in the amount of $ ____ Multiples of $25,000 to $500,000 ☐ Smoker. ☐ Non Smoker. FOR OFFICE USE ONLY

I apply for Accidental Death and Dismemberment for myself in the amount of $ ____ Multiples of $25,000 to $500,000 ☐ Smoker ☐ Non Smoker FOR OFFICE USE ONLY

EMPLOYEE OPTIONAL GROUP LIFE (and Accidental Death, if any) **REVOCABLE BENEFICIARY NOMINATION**

beneficiary's family name, given name, relationship to employee

I hereby nominate the above beneficiary if living, otherwise to my estate, to receive any amount due on my death while insured under this group policy. I reserve the right to change the beneficiary appointed above subject to any statutory regulations.

SPOUSE OPTIONAL GROUP LIFE

beneficiary's family name, given name, relationship to employee

I hereby nominate the above beneficiary if living, otherwise myself (the employee) to receive any amount due on my spouse's death while insured under this group policy. I reserve the right to change the beneficiary appointed above subject to any statutory regulations.
Children's benefits will be payable to myself (the employee).

Signature of Employee _____ Date _____ Signature of Spouse _____
I authorize my employer to deduct from my pay amounts required according to choice of coverage.

NOTE: Your spouse must sign this application if spouse's coverage is being applied for.

OPTIONAL GROUP LIFE INSURANCE
BC LIFE AND CASUALTY

Authorization

☐ I am applying for Optional Group Life Insurance and hereby authorize Human Resources to forward a *copy* of my Enrolment Form and the *original* Statement of Health to BC Life and Casualty Co. ***I have attached my original Group Life Enrolment and Statement of Health forms to this authorization***. I understand that this coverage will be implemented once BC Life and Casualty have approved my application.

_____ _____
Signature Date

or

☐ I am applying for Optional Group Life Insurance and have sent the *original* Statement of Health form and a *photocopy* of my Enrolment Form directly to BC Life and Casualty Co. ***I have attached my original Optional Group Life Enrolment form to this authorization***. I understand that this coverage will be implemented once BC Life and Casualty have approved my application.

_____ _____
Signature Date

Please return this signed form to the Benefits Office in Human Resources, along with the appropriate forms as outlined above.

PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

APPLICATION FOR OPTIONAL LIFE INSURANCE

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | Fax: 604 419-2990

PART 1 — EMPLOYER INFORMATION

Group name	Division	Sub-division	Policy number	ID number	Class number
University of Victoria			40703		

PART 2 — APPLICANT TO COMPLETE

Application for Employee

Name	Sex
	☐ M ☐ F

Date of birth (mm-dd-yyyy)	Occupation

Height (inch/cm)	Weight (lbs/kg)

Employment status	Amount of optional life insurance being applied for
☐ Active ☐ On leave or disability	$

I hereby appoint the following beneficiary for any amount of Optional Life Insurance payable after my death in accordance with the terms of the Policy. I reserve the right to change my appointment of beneficiary as far as it is legally permissible to do so. A person who is insurable under this policy as both an employee and a spouse is still limited to the $500,000.

Beneficiary (full legal name)	Relationship

Employee signature	Date (mm-dd-yyyy)
X	

Member trustee designation — Complete only if a beneficiary is under age 18

I hereby appoint as trustee to receive from Pacific Blue Cross any amount which may be due to my beneficiary, while the beneficiary is a minor:

Full legal name	

Birthdate (mm-dd-yyyy)	Relationship to you

Application for Spouse (if applying)

Name	Sex
	☐ M ☐ F

Date of birth (mm-dd-yyyy)	Occupation

Height (inch/cm)	Weight (lbs/kg)

	Amount of optional life insurance being applied for
	$

I hereby appoint the following beneficiary for any amount of Optional Life Insurance payable after my death in accordance with the terms of the Policy. I reserve the right to change my appointment of beneficiary as far as it is legally permissible to do so. A person who is insurable under this policy as both an employee and a spouse is still limited to the $500,000.

Beneficiary (full legal name)	Relationship

Spouse signature	Date (mm-dd-yyyy)
X	

Member trustee designation — Complete only if a beneficiary is under age 18

I hereby appoint as trustee to receive from Pacific Blue Cross any amount which may be due to my beneficiary, while the beneficiary is a minor:

Full legal name	

Birthdate (mm-dd-yyyy)	Relationship to you

PART 3 — APPLICANT'S STATEMENT OF HEALTH - Pease tick "Y" (yes) or "N" (no) in the appropriate column for each person applying for coverage

If you answer yes to any of these questions, please give complete details in the space provided on page 2.

	applicant		spouse	
	YES	NO	YES	NO
1. Have you ever consulted a physician, ever been treated for, or had any known indication of:				
a) Chest pain or heart disorders?	☐	☐	☐	☐
b) High blood pressure?	☐	☐	☐	☐
c) Cancer or tumors?	☐	☐	☐	☐
d) Diabetes?	☐	☐	☐	☐
e) Arthritis or rheumatism?	☐	☐	☐	☐
f) Nervous or mental disorder?	☐	☐	☐	☐
g) Lung disorder?	☐	☐	☐	☐
h) Small or large bowel disorder?	☐	☐	☐	☐
i) Stomach or liver disorder?	☐	☐	☐	☐
j) Kidney or urinary disorder?	☐	☐	☐	☐
k) Hernia?	☐	☐	☐	☐
l) Back, limb or joint disorder?	☐	☐	☐	☐
m) Blood or circulatory disorder?	☐	☐	☐	☐
n) Hepatitis B or C or B carrier state?	☐	☐	☐	☐
o) Neurological disorder, seizure or multiple sclerosis?	☐	☐	☐	☐
2. Have you:				
a) ever applied for or received benefits, compensation or pension because of sickness or injury?	☐	☐	☐	☐
b) been absent from work because of sickness or injury during the last six months?	☐	☐	☐	☐
c) undergone treatment for alcoholism or drug habit?	☐	☐	☐	☐
3. Are you aware of any symptoms or complaints for which you have not yet consulted a physician or received treatment?	☐	☐	☐	☐
4. Are you, your spouse or dependents taking any prescribed medication? If yes, provide name of medication(s) and reason for use in space provided on the back.	☐	☐	☐	☐
5. Have you:				
a) ever been treated for or had any known indication of Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any other immunological disorder?	☐	☐	☐	☐
b) had any positive test results indicating exposure to the AIDS virus?	☐	☐	☐	☐

	applicant		spouse	
	YES	NO	YES	NO
6. Have you any physical impairments, deformities, or illness not covered in questions 1-5?	☐	☐	☐	☐
7. Have you any physical impairments, deformities, or illness not covered in questions 1-5?	☐	☐	☐	☐
8. Have you consulted any physician in the last two years apart from basic checkups?	☐	☐	☐	☐
9. Have you had any weight change within the last 12 months? If yes, state number of lbs/kgs gained or lost and reason for change in space provided on the back.	☐	☐	☐	☐
10. Have you:				
a) used any tobacco products within in the past 12 months (cigarettes, patch, chewing tobacco, gum, etc.)?	☐	☐	☐	☐
If yes, indicate type, amount and frequency				
b) ever used marijuana, cocaine, hallucinogenic or narcotic drugs, sedatives or tranquilizers, except as prescribed by a physician?	☐	☐	☐	☐
11. Have you engaged or do you intend to engage in any hazardous sports such as motor racing, scuba diving, or hang gliding or have you flown in an aircraft other than as a fare-paying passenger?	☐	☐	☐	☐
a) Blood or circulatory disorder?	☐	☐	☐	☐
b) Hepatitis B or C or B carrier state?	☐	☐	☐	☐
c) Neurological disorder, seizure or multiple sclerosis?	☐	☐	☐	☐
11. Have you or your spouse had a request for life or health insurance declined, postponed, rated, or restricted in any way?	☐	☐	☐	☐
12. Do you or your spouse now have or are you applying for other life or disability income insurance? If yes, indicate type of insurance, amount, benefit and elimination periods as applicable in space provided on the back.	☐	☐	☐	☐

Please tick "Employee" or "Spouse" on the left and give complete details of all questions answered "Y" (yes) on previous page.
If additional space is needed, use separate sheet.

	Illness/Condition and/or Medication	Dates and Duration	Treatments and Results (fully recovered or remaining effects)	Names and full address of doctor(s) or hospital(s)
☐ Employee ☐ Spouse Question#				
☐ Employee ☐ Spouse Question#				
☐ Employee ☐ Spouse Question#				
☐ Employee ☐ Spouse Question#				
☐ Employee ☐ Spouse Question#				

PART 4 — FAMILY MEDICAL HISTORY

	applicant		spouse	
	YES	NO	YES	NO
Have your parents or siblings ever had cancer, high blood pressure, heart or kidney disease, diabetes, mental or nervous disorder? If yes, give complete details in the space provided:	☐	☐	☐	☐

		Age (if living or age at death)	Details of any health disorder	Cause of death (if applicable)
☐ Employee ☐ Spouse	Father			
☐ Employee ☐ Spouse	Mother			
☐ Employee ☐ Spouse	Siblings			

PART 5 — AUTHORIZATION

I declare all recorded answers included on this form are full, complete and true as of this date.

I authorize any person or institution, including the Medical Information Bureau, that has any records or knowledge of my health to give Pacific Blue Cross and its reinsurers any such information. I understand this information will be used by Pacific Blue Cross to determine my eligibility for coverage and may be used in connection with any claim filed with Pacific Blue Cross. A photocopy of this authorization shall be as valid as the original.

I acknowledge receipt of written notification describing the use of the Medical Information Bureau.

I, the employee, authorize the necessary payroll deductions.

Address	Postal code	**Phone**
Employee's signature **X**	EMAIL	Date (mm-dd-yyyy)
Spouse's signature **X**	EMAIL	Date (mm-dd-yyyy)

Please recheck the form and make sure all questions on both sides have been answered. If all the requested information is not provided, this form will be returned to you for further completion. Mail to: PO Box 7000, Vancouver, BC V6B 4E1.

NOTIFICATION – Please read carefully and detach for your own records.

Information regarding your insurability will be treated as confidential. Pacific Blue Cross or its reinsurers may, however, make a brief report to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction.
Their address is: Medical Information Bureau, 330 University Avenue, Toronto, Ontario, Canada, M5G 1R7.

Pacific Blue Cross may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

UVic Optional Life FAQ

Timelines:

1. How long can I expect my application to take?
    a. Generally, PBC has committed to a 5-day turnaround for decision **once all of the required information is received**.
    b. Many applications do require additional information that may require input from your physician or further testing.
2. Why can the process take so long?
    a. As some applications may require additional medical information, the process may be delayed due to physician scheduling and testing requirements.
    b. Additional medical reports will be requested directly from your physician
    c. If testing is required, you will be informed directly and a representative from the Testing Facility will work with you to schedule the appropriate tests.
3. Who can I reach out to for an update on my application:
    a. Application updates can be requested by emailing medunderwriting@pac.bluecross.ca
4. Who can I contact to make general inquiries about applying for Optional Life coverage?
    a. Questions about optional life applications should be directed to your UVic Benefits Advisor.

Process:

1. Once PBC receives optional life application:
    a. PBC Member Administration confirms the Applicant's Evidence of Insurability (EOI)
        i. 10 business days to confirm eligibility
    b. Once confirmed, the application is sent to Medical Underwriting
    c. Initial review is completed within 5 days of receipt. This review will also determine if further medical information is required

2. If further medical is required?
    a. An email will be sent to the applicant informing of need for additional information
    b. If an attending physician statement is required:
        i. The Physician will be contacted directly. There will be no need for the Applicant to facilitate this request.
    c. If testing is required:
        i. A 3rd party medical testing facility will contact the applicant to arrange for the requisite tests.

Application Decisions:

1. Once a decision is made, PBC will send an email to the UVic Benefits Advisor.
    a. If approved
        i. An email will be sent to your UVic Benefits Advisor indicating an approved application
    b. If declined
        i. An email will be sent to your UVic Benefits Advisor indicating a declined application
        ii. A letter will also be sent to you indicating:
            1. Claim denial
            2. Reasons for denial
            3. Appeal options