Public Service Health Care Plan (PSHCP) Positive Enrolment Form

Plan number
Certificate number

Instructions

- You can complete your positive enrolment online at canadalife.com/pshcp, rather than submitting a paper form.
- Any incomplete or illegible form will be returned to you by mail for re-submission.
- Complete all sections of the form. **PRINT clearly in ink, sign, date and mail it to:**

  Canada Life
  PSHCP Positive Enrolment
  PO Box 6000 Stn Main
  Winnipeg, MB R3C 3A5

Questions? Visit canadalife.com/pshcp or call us at 1-855-415-4414, Monday to Friday 8 am to 5 pm, your local time.

☐ **I am completing my positive enrolment for the first time with Canada Life.**
☐ **I have already done my positive enrolment and need to make a change.**

1 Your contact information

Last name	First name	Preferred first name

Date of birth (mmm-dd-yyyy)	Gender ☐ Male ☐ Female ☐ Other ☐ Prefer not to answer

Mailing address (street number and name, and/or P.O. Box)	Apartment

City	Province/Territory/State	Postal/Zip code	Country

Current country of residence for Comprehensive Members	The current country of residence is where you are currently residing, working, deployed or posted to. This can differ from your mailing address.
Canadian province or territory for health care	Province or territory where you are covered for provincial or territorial health coverage when you are in Canada.

2 Preferred method of communication

How do you want to be contacted?

Please select only one. If both are selected, we will consider that your preferred method of communication is email.

☐ Email (provide email address)

☐ Paper (communications will be sent to the mailing address you provided in section 1)

3 Your coordination of benefits information

Apart from the PSHCP, do you have other health care coverage as a Member? ☐ Yes ☐ No If yes, please complete the questions below.

What benefits are you covered for under your other plan (select all that apply)? ☐ Health ☐ Drugs ☐ Vision

Is your other coverage with Canada Life? ☐ Yes ☐ No If yes, plan number: Member ID:

Are you a retiree under your other plan? ☐ Yes ☐ No If no, which plan started first? ☐ The PSHCP ☐ The other plan

4 Information about your eligible spouse or common-law partner

Reason for change: ☐ Add ☐ Change ☐ Remove Effective date (mmm-dd-yyyy)

Last name	First name

Date of birth (mmm-dd-yyyy)	Gender ☐ Male ☐ Female ☐ Other ☐ Prefer not to answer

Is your spouse or common-law partner covered under another group health care plan? ☐ Yes ☐ No If yes, please complete the questions below.

What benefits are they covered for (select all that apply)? ☐ Health ☐ Drugs ☐ Vision

Does your spouse or common-law partner have their own coverage under the PSHCP? ☐ Yes ☐ No

If yes, provide your spouse or common-law partner's PSHCP certificate number:

If no, is the other coverage with Canada Life? ☐ Yes ☐ No If yes, plan number: Member ID:

M7515-10/24

PSHCPEN2

5 Information about your eligible dependant children

Dependant 1

Reason for change: ☐ Add ☐ Change ☐ Remove Effective date (mmm-dd-yyyy)

Last name	First name
Date of birth (mmm-dd-yyyy)	Gender ☐ Male ☐ Female ☐ Other ☐ Prefer not to answer

☐ Dependant child (under age 21)
☐ Child with a disability (age 21+)
☐ Full-time student (if between ages 21-25) If full-time student:

- Institution name
- Program name Program end date (mmm-dd-yyyy)

Is your dependant covered as a member or dependant under another group health care plan? ☐ Yes ☐ No If yes, please complete the questions below:

What benefits are they covered for (select all that apply)? ☐ Health ☐ Drugs ☐ Vision

Is your dependant's other coverage with another parent or guardian? ☐ Yes ☐ No If yes, provide the name and date of birth of the other parent or guardian:

Last name First name Date of birth (mmm-dd-yyyy)

Is the other coverage with Canada Life? ☐ Yes ☐ No If yes, plan number: Member ID:

Dependant 2

Reason for change: ☐ Add ☐ Change ☐ Remove Effective date (mmm-dd-yyyy)

Last name	First name
Date of birth (mmm-dd-yyyy)	Gender ☐ Male ☐ Female ☐ Other ☐ Prefer not to answer

☐ Dependant child (under age 21)
☐ Child with a disability (age 21+)
☐ Full-time student (if between ages 21-25) If full-time student:

- Institution name
- Program name Program end date (mmm-dd-yyyy)

Is your dependant covered as a member or dependant under another group health care plan? ☐ Yes ☐ No If yes, please complete the questions below:

What benefits are they covered for (select all that apply)? ☐ Health ☐ Drugs ☐ Vision

Is your dependant's other coverage with another parent or guardian? ☐ Yes ☐ No If yes, provide the name and date of birth of the other parent or guardian:

Last name First name Date of birth (mmm-dd-yyyy)

Is the other coverage with Canada Life? ☐ Yes ☐ No If yes, plan number: Member ID:

M7515-10/24

5 Information about your eligible dependant children (continued)

If you need to add more than four dependants, use a photocopy of this form.

Dependant 3

Reason for change: ☐ Add ☐ Change ☐ Remove Effective date (mmm-dd-yyyy)

Last name	First name
Date of birth (mmm-dd-yyyy)	Gender ☐ Male ☐ Female ☐ Other ☐ Prefer not to answer

☐ Dependant child (under age 21)
☐ Child with a disability (age 21+)
☐ Full-time student (if between ages 21-25) If full-time student:
- Institution name
- Program name Program end date (mmm-dd-yyyy)

Is your dependant covered as a member or dependant under another group health care plan? ☐ Yes ☐ No If yes, please complete the questions below:

What benefits are they covered for (select all that apply)? ☐ Health ☐ Drugs ☐ Vision

Is your dependant's other coverage with another parent or guardian? ☐ Yes ☐ No If yes, provide the name and date of birth of the other parent or guardian:

Last name First name Date of birth (mmm-dd-yyyy)

Is the other coverage with Canada Life? ☐ Yes ☐ No If yes, plan number: Member ID:

Dependant 4

Reason for change: ☐ Add ☐ Change ☐ Remove Effective date (mmm-dd-yyyy)

Last name	First name
Date of birth (mmm-dd-yyyy)	Gender ☐ Male ☐ Female ☐ Other ☐ Prefer not to answer

☐ Dependant child (under age 21)
☐ Child with a disability (age 21+)
☐ Full-time student (if between ages 21-25) If full-time student:
- Institution name
- Program name Program end date (mmm-dd-yyyy)

Is your dependant covered as a member or dependant under another group health care plan? ☐ Yes ☐ No If yes, please complete the questions below:

What benefits are they covered for (select all that apply)? ☐ Health ☐ Drugs ☐ Vision

Is your dependant's other coverage with another parent or guardian? ☐ Yes ☐ No If yes, provide the name and date of birth of the other parent or guardian:

Last name First name Date of birth (mmm-dd-yyyy)

Is the other coverage with Canada Life? ☐ Yes ☐ No If yes, plan number: Member ID:

M7515-10/24

6 Authorization and declaration

- The Plan Sponsor is the Government of Canada.
- The Federal Public Service Health Care Plan Administration Authority is the corporation charged with the administration of the PSHCP.
- The contracted Plan Administrator is The Canada Life Assurance Company (Canada Life).
- Personal information, for the purposes of this Consent, means the personal information described in the Public Service Health Care Plan (PSHCP) Privacy Statement, the Public Service Dental Care Plan (PSDCP) Privacy Statement and the Pensioners' Dental Services Plan (PDSP) Privacy Statement.

The Government of Canada collects, handles, and retains personal Information for the purpose of administering the PSHCP, PSDCP and the PDSP in accordance with Canada's Privacy Act. The PSHCP Privacy Statement, PSDCP Privacy Statement and the PDSP Privacy Statement have been developed to comply with the Privacy Act.

As the contracted Plan Administrator, Canada Life has agreed to comply with the Privacy Act. Canada Life is subject to other applicable privacy legislation in jurisdictions where it operates. Canada Life posts its Privacy policy on its website. Where there is a difference between the Privacy Act and this other legislation, Canada Life will apply the most stringent requirements. Your personal information and that of any eligible dependants will be maintained securely and in a confidential manner. Your personal information is used to administer your coverage including verifying your identity, maintaining your positive enrolment information, evaluating your eligibility, collecting feedback on customer service, and protecting all parties from risks such as fraud.

Access to your personal information is limited to persons who require it to perform their duties, and to persons you have granted access. Your information may be shared between the Plan Administrator and its subcontractors in support of the PSHCP, PSDCP and/or PDSP (whichever plans you are enrolled in with Canada Life) to facilitate the administration of services. Your personal information may be disclosed to health care providers, other insurance or reinsurance companies, claims processing providers, technology suppliers, and other service providers referred to in the PSHCP Privacy Statement, PSDCP Privacy Statement and the PDSP Privacy Statement or Canada Life's Privacy policy. Your personal information may also have to be disclosed to public and government authorities under applicable law in Canada or elsewhere. Your personal information may be collected or communicated outside of Canada or outside your province of residence as part of day-to-day business.

You can exercise your privacy rights through Canada Life's privacy centre such as access to or correction of your personal information. If you choose to remove your consent to the collection, use and disclosure of personal information required to serve you and meet our legal obligations, Canada Life will not be able to continue to administer your benefits and adjudicate claims under the plan(s) in which you are enrolled, or coordinate your benefits with other plans.

Declarations

1. I have read and I understand the PSHCP Privacy Statement, PSDCP Privacy Statement and the PDSP Privacy Statement (whichever plans you are enrolled in with Canada Life) and Canada Life's Privacy policy.
2. I agree the Plan Sponsor, The Federal Public Service Health Care Plan Administration Authority (for the PSHCP only), Canada Life and its service providers, and other entities referred to above may collect, use and disclose personal information about me and my dependants for the administration of the PSHCP, PSDCP and/or the PDSP (whichever plans you are enrolled in with Canada Life), including the adjudication of claims. This includes the use and disclosure with other persons and organizations who have, or require, the information for these purposes.
3. I have obtained the consent of my dependants over 18 years of age to their enrolment in the PSHCP, PSDCP and/or PDSP (whichever plans you are enrolled in with Canada Life) and to the use and disclosure of their personal information for the above purposes.
4. I agree to the use and disclosure of personal information about my dependants under 18 years of age to enrol them in the PSHCP, PSDCP and/or PDSP (whichever plans you are enrolled in with Canada Life) and for the above purposes.
5. I confirm all dependants I have identified meet the PSHCP, PSDCP and/or PDSP (whichever plans you are enrolled in with Canada Life) eligibility requirements and the information I have provided is complete and accurate.
6. I agree to review and keep up to date all my and my dependant's information.
7. I agree to validate and/or update my personal information and, where applicable, the information of my dependants through the completion of the biennial confirmation process. My failure to complete the biennial confirmation process may result in my dependant's claims being suspended until it has been completed.
8. I agree that the information that I reviewed, validated or updated regarding myself and my dependants be shared between the Plan Administrator and its subcontractors in support of the PSHCP, PSDCP and/or PDSP (whichever plans you are enrolled in with Canada Life) to facilitate the administration of services.
9. I confirm all goods and services for which reimbursement is claimed by me or my dependant(s) will have been received by me or my dependant(s). In the case of overpayments and/or erroneous payments which I have not reimbursed to Canada Life, I agree that Canada Life may disclose this personal information to the Plan Sponsor, specifically the Treasury Board of Canada Secretariat. The Plan Sponsor/Treasury Board of Canada Secretariat may disclose this personal information to government institutions so that the overpayments and/or erroneous payments and associated interest (if applicable) can be deducted or set-off from any money due or payable to me by His Majesty.
10. If banking information was provided, I authorize Canada Life to deposit claim payments directly to the account provided.
11. If banking information was provided for Veterans Affairs Canada members for the purpose of contribution collection, I authorize Canada Life to withdraw from the identified bank account.

Signature

I agree to the submission of the information on this application to Canada Life for enrolling in the PSHCP, PSDCP and/or PDSP (whichever plans you are enrolled in with Canada Life), and I am providing the consent and declarations listed above. A photocopy or electronic version of this signed application is as valid as the original.

Signature X _____ **Date (mmm-dd-yyyy):** _____

M7515-10/24

PSHCPEN2

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