***The information requested on this form is being collected pursuant to the Freedom of Information and Protection of Privacy (FOIP) Act, notably Sections 33, 34, 39 and 40, and is restricted to Division personnel responsible for administering Payroll and Benefits.***

|  |
| --- |
| Name (as it presently appears on cheques):       |
| Employee Number:       | Date of Employment with Rocky View Schools:       |

***\*\*Please complete this form only in the specific areas requiring change to your Payroll and/or Personnel records\*\****

|  |  |  |  |
| --- | --- | --- | --- |
| List spouse and dependents with dates of birth: | Relationshipto Employee | BirthdateYYYY/MM/DD | Student |
| Name:       | [ ]  Male [ ]  Female  |       |       | [ ]  Yes[ ]  No |
| Name:       | [ ]  Male [ ]  Female |       |       | [ ]  Yes[ ]  No |
| Name:       | [ ]  Male [ ]  Female |       |       | [ ]  Yes[ ]  No |
| Name:       | [ ]  Male [ ]  Female |       |       | [ ]  Yes[ ]  No |

**BENEFIT CHANGES:**

|  |
| --- |
| Provide reason for change:       |
| **SUPPLEMENTARY HEALTH CARE** |
| SINGLE [ ]  $83.36/month | COUPLE [ ]  $166.75/month | FAMILY [ ]  $250.10/month |
| NOT ELIGIBLE [ ]  | WAIVED [ ]  *(attach letter from spouse's employer confirming coverage)* |
| **It is mandatory to provide the following information:**  |
| **SPOUSE’S PLAN PROVIDER**  |
| Manulife: [ ]  | Plan Number:       | Certificate Name:       |
| Other:       | Plan Number:       | Certificate Name:       |
| Benefit Coverage: Single [ ]  Family [ ]  None [ ]  |
| **DENTAL INSURANCE:** |
| *Any changes to the Family Coverage without notification will result in conditions specified in the insurance policy.*  |
| SINGLE [ ]  $58.65/month | COUPLE [ ]  $117.30/month | FAMILY [ ]  $175.95/month |
| NOT ELIGIBLE [ ]  | WAIVED [ ]  *(attach letter from spouse's employer confirming coverage*  |
| **It is mandatory to provide the following information:**  |
| Spouse’s Employer:       |
| Benefit Coverage: Single [ ]  Family [ ]  None [ ]  |

*Reference: AP400 Staff Employment*

**BENEFICIARY CHANGES:**

|  |
| --- |
| **LIFE INSURANCE, A.D.&D** |
| Revocable Beneficiary:       |
| Surname:       | Given Name:       |
| Relationship:       |
| Effective Date of Change:        |
| Signature:       |

**TEAHCERS’ RETIREMENT FUND and LOCALS AUTORITIES PENSION PLAN (support staff)**

\*\*Change Forms will be supplied when requested or required\*\*

|  |
| --- |
| **I hereby declare that I have read and understood the information contained on this form and the use of personal information and the information I have provided is correct. I authorize the changes necessary to appear on my Payroll and Personnel records. If contributions towards premiums are necessary, I also authorize the necessary deductions from my earnings.** |
| School:       |
| Signature:       | Date:       |

*If you have any questions regarding this request for personal information and the use of this*

*information, please contact the Payroll Officer or the R.V.S. FOIP Coordinator at 403.945.4013.*

|  |
| --- |
| **Submit to the Benefits Department** Rocky View Schools Education Centre |

|  |
| --- |
| **EFFECTIVE DATE:**  |
| **DATE:**  |
| **MANULIFE INFORMED:** **[ ]**  |

*Reference: AP400 Staff Employment*