SEIU Locals 1 & 2 Benefit Trust Fund

ADMINISTERED BY GLOBAL BENEFITS

88 St. Regis Crescent South, Toronto ON M3J1Y8
Voice: 416-635-6000 • Fax: 416-635-6464
seiubenefittrust@globalben.com

SEIU Local 1 Healthcare *(Circle of Care)* **5937«Drugcardno»**
«FirstNameUPPER» «LastNameUPPER»
«Address1UPPER»
«CityUPPER» «Prov» «PostalCode»

To:	Members of SEIU Local 1 Health Care who are Fulltime Employees of Circle of Care
From:	Board of Trustees SEIU Locals 1 & 2 Benefit Trust Fund
Re:	Extended Health Care Benefits effective January 1, 2022
Date:	December 2021

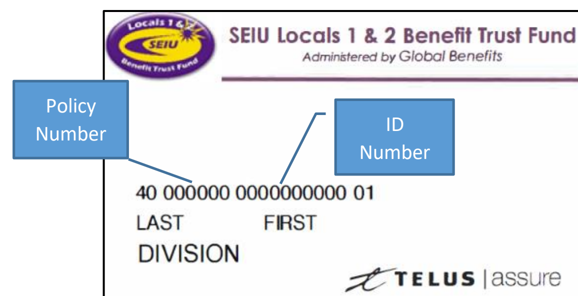
During your last round of Collective Bargaining, your Union negotiated an Extended Health Benefit and Dental Care package for you and your family. Coverage is available to all fulltime employees. A fulltime employee is defined as someone who worked 1300 or more hours in the previous year.

Your Prescription Drug Card

Enclosed is your SEIU Locals 1 & 2 benefit card which can be used at your pharmacy and your dental care provider.

At this time, your card has been activated however, in order to maintain active status as well as to include your family members, you must complete and return the attached Enrolment Form in the postage-paid envelope provided ***not later than January 28, 2022***.

When contacting Global Benefits, you will need your Policy Number and ID Number from your Prescription Drug Card:



Only one card *(for the eligible member)* is included with this mailing. For members requesting family coverage, family status will be applied and additional cards will be sent following receipt of your completed Enrolment Form.

Card Activation	Your SEIU Locals 1 & 2 Benefit Trust Fund benefit card is effective January 1, 2022.
Benefit Summary	Please see enclosure Included as part of this information package.
Plan Member Responsibilities	If you experience a change in your family status (birth, death, marriage, divorce, etc.), you must advise your plan administrator within 31 days of the event by completing a new Enrolment Form. If the insurance underwriter isn't notified within 31 days of such change, medical evidence may be required, limitations may be placed on coverage, or coverage may be declined. Enrolment Forms are available by request from the Administrator at 416-635-6000 or seiubenefittrust@globalben.com
Electronic Claims Payments (Direct Deposit)	You will need to register with Global Benefits if you wish to authorize Electronic Claims Payments. You can sign up for this service on the Global Benefits app or website portal. You can also mail/email your banking information to the address contained in this letterhead. In addition to your name and Member ID, please include the following bank information: Financial Institution name and transit number, Account Holder's name and account number.

Global Benefits Online Access

Using the Global Benefits app or website portal, you can review your Schedule of Benefits, submit a claim, sign up for direct deposit, view your contributions/ hours, and more.

The username and password will be the same for both the website portal and the mobile app.

• Website Portal

To activate this service

you must register for Plan Member Online Access by clicking on the *Register Here* link at www.globalben.com

(For easy access to Global's website, use your phone to scan the QR code)

• Global Benefits App

Download for iOS or Android

Our free app is optimized for both phone and tablet (iOS and Android). The app registration process is similar to the website registration process.

Once the setup is complete

you will receive an email asking you to confirm registration by clicking the link in the email. Following confirmation, you will receive another email with a link to personalize your password.

If you have any questions or concerns

please call Global Benefits and ask for Online Registration.

416-635-6000

SEIU Locals 1 & 2 Benefit Trust Fund Circle of Care

Extended Health Care	
Deductible:	NIL
Co-Insurance:	80% Drugs and Dental 100% All other expenses
Late Submission:	12 months
Termination Of Coverage	Can continue coverage for EHC & Dental at age 70 as long as employer contributes for Med & Dent. Benefits only

EMPLOYEE LIFE INSURANCE AND A D & D	
Active Employees	$30,000 Reduced to 50% at age 65 - Termination at age 70

Benefit Provision	**Comments**
Prescription Drugs (Pay Direct Drug Card)	Prescription by law – 80% -$5000 per calendar year
Medical Transportation Service	Emergency Ambulance
Paramedical Services	$50 per visit up to a maximum of $350 per calendar year for each specialty (Member Only) – Chiropractor, Osteopath, Naturopath, Podiatrist/Chiropodist, Massage Therapist, Speech Therapist, Physiotherapist, Psychologist, Acupuncturist
Therapeutic Devices (Insulin Pump, Blood Glucose Monitor, Burn Treatment Garments & Fracture Consolidation Stimulators)	$10,000/lifetime
External Prosthesis (including Breast Prosthesis, Artificial Eyes & Artificial Limbs)	$5000/lifetime
Hearing Aids	$300/36 months
Respirator – Breathing Apparatus (e.g. CPAP & Supplies)	$10,000/lifetime
Surgical Bra	2 per calendar year
Surgical Hose (over 20mm/Hg)	2 pair up to a max of $200 per calendar year
Vision care - including eye exams	$250/24 months
Wig	$300/lifetime

Dental Care	**Comments**
Annual Maximum	$750
Fee Schedule	Current Fee Guide For General Practitioners In Province Of Residence
Basic Services Included	Diagnostic, Preventative, Restorative, Oral Surgery, Anaesthesia

SEIU Locals 1 & 2 Benefit Trust Fund

Group Benefit Enrolment and Beneficiary Designation Form

Administrator:
Global Benefits
Telephone: 416-635-6000
Fax: 416-631-3064
Email: benefits@globalben.com
88 St. Regis Crescent South
Toronto, ON M3J 1Y8

Please type or print clearly. Complete all items on both sides of the form in detail. To ensure that coverage is kept up to date for you and your dependents, it is vital that you advise your Plan Administrator of any changes such as change of name, marital status, dependent status, or change of beneficiary.

OFFICE USE ONLY
Circle of Care

Plan Member Information

Last Name ______ First Name ______ Initial ______ Social Insurance Number ___ - ___ - ___

Apt. Number/Street Number/Street Name ______ City ______ Province ______ Postal Code ______

Home Phone ( ) ______ Cell Phone ( ) ______ Email Address ______

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Common Law ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Member's Date of Birth ______ mm/dd/yyyy

Initiation Date ______ mm/dd/yyyy

Date of marriage or if common law date on which cohabitation period started ______ mm/dd/yyyy

Dependent Information

This section allows you to define who will be entitled to your Health and Group Legal Benefits. If you require additional fields please complete another form and submit together.

Spouse

Last Name	First Name	Date of Birth mm/dd/yyyy	Sex	Is this individual covered by another group insurance plan?
			☐ M ☐ F	☐ Yes ☐ No

Children and Dependents

Last Name	First Name	Date of Birth mm/dd/yyyy	Sex	Is this individual covered by another group insurance plan?
			☐ M ☐ F	☐ Yes ☐ No
			☐ M ☐ F	☐ Yes ☐ No
			☐ M ☐ F	☐ Yes ☐ No
			☐ M ☐ F	☐ Yes ☐ No

Primary Beneficiary Designation

This section must be completed to designate a beneficiary for your life benefits and other benefits which may become payable under the Benefit Trust upon your death. If no beneficiary is named or the primary beneficiary predeceases you, the proceeds shall be paid to your estate.

I hereby revoke all previous Primary beneficiary designations and designate the following as beneficiary(ies). The sum of all percentages must add to 100%. You may leave the % fields blank if you wish to divide the proceeds equally among all the names listed in this section.

Primary Beneficiary | **Percent Allocated** | **Relationship to Plan Member**

Last Name ______ First Name ______ ______ % ______

Apt. Number/Street Number/Street Name ______ City ______ Province ______ Postal Code ______

Last Name ______ First Name ______ ______ % ______

Apt. Number/Street Number/Street Name ______ City ______ Province ______ Postal Code ______

Last Name ______ First Name ______ ______ % ______

Apt. Number/Street Number/Street Name ______ City ______ Province ______ Postal Code ______

CONTINUED ON NEXT PAGE

Contingent Beneficiary Designation

If you wish to appoint a contingent beneficiary in the event that there are no surviving primary beneficiaries at the time of your death, please complete this section. If there are no Contingent Beneficiaries at the time of my death, the proceeds shall be paid to your estate.

I hereby revoke all previous Contingent beneficiary designations and designate the following as beneficiary(ies)

Contingent Beneficiary | Percent Allocated | Relationship to Plan Member

______________________________ __________ % ______________

Last Name First Name

____

Apt. Number/Street Number/Street Name City Province Postal Code

______________________________ __________ % ______________

Last Name First Name

____

Apt. Number/Street Number/Street Name City Province Postal Code

Privacy

This section explains Global Benefits commitment to privacy.

At Global Benefits we recognize and respect the importance of privacy.

Your personal information:
When you apply for coverage, we establish a confidential file that contains your personal information like your name, contact information, and products and coverage you have with us and may also include financial or health information. Your information is kept in the offices of Global Benefits or the offices of an organization authorized by Global Benefits.

Who has access to your information:
We limit access to personal information in your file to Global Benefits staff or persons authorized by Global Benefits who require it to perform their duties and to persons to whom you have granted access. Your personal information may also be subject to disclosure to public authorities or others authorized under applicable law within or outside Canada.

What your information is used for:
Personal information that we collect will be used for the purposes of determining your eligibility for products, services or coverage for which you apply, providing, administering or servicing products or coverage you have with us, and for Global Benefits and its affiliates' internal data management and analytics purposes.

If you want to know more:
If you have questions about our personal information policies and practices, write to SEIU Locals 1 & 2 Benefit Trust c/o Global Benefits Chief Compliance Officer at:

SEIU Locals 1 & 2 Benefit Trust
c/o Global Benefits
88. St. Regis Crescent South
Toronto, ON M3J 1Y8

T: (416) 635-6000 F: (416) 631-3064
E: privacyofficer@globalben.com

Authorizations and Declarations

This section must be signed and dated by the plan member.

I have read and understand and agree with the contents of the section on this form entitled "Privacy".

I authorize:

Global Benefits, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Global Benefits or the above to exchange personal information, when necessary to determine eligibility for coverage and to administer the plan.

I agree that a photocopy or electronic copy of the Authorizations and Declarations section valid as the original.

I authorize the use of my Social Insurance Number as my Certificate Number under the group plan and as my identification number in the **SEIU Locals 1 & 2** Benefit Trust Fund database.

I certify that the information given is true, correct and complete to the best of my knowledge.

Plan member signature: ____________________________ **Date:**______________
mm/dd/yyyy