NANAIMO LADYSMITH PUBLIC SCHOOLS

From the Department of Payroll & Benefits

TEACHER ON CALL BENEFIT FORM

SURNAME	FIRST NAME	EMPLOYEE NUMBER

I hereby certify that I have read and understand the conditions under which I am entitled to benefits under Article 9.7.2 of the Collective Agreement. I understand that once I have received all applicable forms they must be completed and returned within 30 days of receipt of the forms.

I would like to be enrolled in the following benefit plan(s):

☐ **EXTENDED HEALTH**
- ☐ Single coverage $133.87/month
- ☐ Couple coverage $240.97/month
- ☐ Family coverage $307.91/month

☐ **Dental**
- ☐ Single coverage $82.05/month
- ☐ Couple coverage $162.19/month
- ☐ Family coverage $266.90/month

I am aware that the costs indicated are current rates and that if they change at any time I will be responsible for payment of the increased rates retroactive to the time the rates were changed.

Signature	Date Signed

July 1, 2025

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