MUNICIPAL EMPLOYEES BENEFITS PROGRAM
PENSION & DISABILITY INCOME PLAN (if applicable)
ENROLLMENT FORM

Employer Number _____ **Employer Name** _____

MEBP USE: Plan Code | | |

EMPLOYEE INFORMATION (to be completed by the employee)

Name _____ S.I.N. _____

Mailing Address _____
Box Number or Street Address Village /Town/City Province Postal Code

Home Phone #:_____ Cell#_____ Email (Optional)_____

Date of Birth _____ Gender: ☐ Male ☐ Female
dd/mmm/yyyy

Proof of age is required (Submit with this enrolllment form a copy of ONE of the following: Birth Certificate, Baptismal Certificate, an unexpired Canadian Passport or Canadian Citizenship Document).

PRIOR EMPLOYERS DURING LAST 12 MONTHS:

Name _____ Period Employed _____

Name _____ Period Employed _____

SPOUSE/COMMON-LAW PARTNER INFORMATION (to be completed by the employee)

Name of spouse or common-law partner:_____

If common-law, date common-law relationship began:_____
dd/mmm/yyyy

MEBP provides plan members with an Annual Benefits Statement. The *Pension Benefits Act* requires that plan administrators collect and report the name of a spouse or common-law partner on the annual statement. The Spouse or common-law partner must meet The Manitoba Pension Benefits Act's definition of eligible Spouse or Common-Law Partner are available on page 2 of the Beneficiary Designation and Change Form #25.

EMPLOYMENT INFORMATION (to be completed by the employer)

Employment Start Date:_____ **Participation:** ☐ Compulsory ☐ Voluntary
dd/mmm/yyyy

Plan Entry Date*_____ dd/mmm/yyyy * *Plan entry date will be the first day of employment OR the first day of pay period depending on if enrollment is Voluntary or Compulsory.*

Annual Base Hours:_____ **Job Title:**_____
(see reverse for more information)

Employment Type: ☐ **Full Time,** Annual Rate of Pay: $_____
Effective date of Full Time status** if not the same as Employment Start Date_____
dd/mmm/yyyy

☐ **Part Time** ☐ **Seasonal** ☐ **Temporary****: Rate of Pay: $_____per hour

Estimated hours that will be worked per pay period:_____
Pay period frequency: ☐ bi-weekly ☐ semi-monthly ☐ monthly ☐ other_____

****If Part Time, Seasonal, Temporary OR status changed to Full time status prior to enrollment indicate the gross annual earnings for each year employed:**

Year	Earnings
	$
	$
	$

ANNUAL BASE HOURS

Annual Base Hours are the hours that a full time employee in the stated job position would be required to work in a full year. A full time employee for MEBP purposes is considered to be someone who works a **minimum** of 6 hours per day, 5 days a week. Therefore, the **minimum** Annual Base Hours that can be used is 6 hours x 5 days a week x 52 weeks=**1560** hours. The **maximum** Annual Base hours are **2600 (**10 hours per day, 5 days a week)

Another example: Another job position would require a full time employee to work 8.00 hours per day, the Annual Base Hours for this position are 8.00 hours x 5 days a week x 52 weeks = **2080**.

***The base hours should be the same for all employees who do the same job/position regardless if they are Full time or Part time*.** The Base Hours the employer states on this form should be used on the Employers Year End Report. They will not change unless the employee moves to a different job/position that has different base hours or a decision is made to change the base hours for all employees in a particular job position. **For a detailed explanation of Annual Base Hours refer to Part 6 of the Employer's Manual.**

DISABILITY INCOME PLAN – (if applicable – please check with your employer)

When an employee joins the Pension Plan, they are automatically enrolled in the Disability Income Plan (DIP), unless the employer does not participate in this plan. Members who are age 64 & 8 months on the enrollment date are not eligible to participate in the DIP.

DESIGNATION OF BENEFICIARY (to be completed by the employee)

Please complete and attach the Beneficiary Designation and Change Form (# 25) to this enrollment form. This form is to be used to designate a beneficiary for the Municipal Employees Pension Plan.

GROUP INSURANCE PLAN – (if applicable – please check with your employer)

If your employer participates in the Group Insurance Plans please make sure that the following forms are completed and sent in along with this enrollment form: BLUE CROSS/MEBP Individual Application For Group Benefits and the Application/Change Form – Voluntary Accidental Insurance (Form #78).

EMPLOYEE DECLARATION AND SIGNATURE

I understand that personal, and if applicable, health information is collected under the authority of *The Freedom of Information and Protection of Privacy Act* and *The Personal Health Information Act* and that a photocopy of this signed consent is sufficient to allow for the disclosure of information. I also understand that the personal information provided above is being collected for the purposes of determining my eligibility for coverage and administering the MEBP. This includes investigating and assessing claims, and creating and maintaining records concerning our relationship. I acknowledge and consent to the MEBP accessing personal information from my employer in the process of investigating and assessing any claims.

I further understand that the MEBP will limit access to personal information in my file to the MEBP staff or persons authorized by the MEBP who require it to perform their duties, to persons to whom I have granted access, and to persons authorized by law.

I acknowledge that I may exercise certain rights of access and rectification with respect to the personal information in my file by contacting the MEBP Administration Office by telephone at 1-800-432-1908 or (204) 926-7979 or by mail at the address stated below.

I also acknowledge that I have read this form and reviewed the terms and conditions of the Plan(s) with my employer and that the information provided in this form is true, correct and complete to the best of my knowledge.

Date _____ **Employee's Signature** _____
dd/mmm/yyyy

Date_____ **Witness Signature**_____
dd/mmm/yyyy *Witness must be over the age of 18.*

EMPLOYER SIGNATURE

Date _____ **Authorized Officer's Signature** _____
dd/mmm/yyyy *Cannot be the same person being enrolled*

Phone No. _____ **Name of Authorized Person** _____
dd/mm/yyyy *Please print*

Municipal Employees Benefits Program
PO Box 764, Winnipeg MB R3C 2L4