

DUFFERIN-PEEL CATHOLIC DISTRICT SCHOOL BOARD

CERTIFIED OCCASIONAL TEACHERS
GROUP BENEFIT PLAN

Under the terms of the OECTA-OI Collective Agreement, you are entitled to enroll in the Board's group plans covering semi-private hospitalization, major medical and dental care up to the age of 65. Enrollment is offered twice per year on November 1st and March 1st. Should you elect to enroll for any of these benefits you are responsible for 100% of the cost of each benefit.

Semi-Private Hospitalization

Semi-private hospital coverage pays for the difference in cost between a ward room (covered by OHIP) and a semi-private room in a hospital.

Single	\$ 15.88	per month
Family	\$ 53.76	per month

Major Medical

The major medical benefit covers the cost of prescription medication, \$200 for vision care per person per year, out of country medical expenses, the difference in cost between a semi-private room and a private room in a hospital, and more. There is an annual deductible of \$10 single coverage and \$20 family coverage.

Single	\$ 61.14	per month
Family	\$190.04	per month

Dental

Dental coverage is based on the current year's ODA fee guide. The plan covers:

- A) 100% of cost of basic services
- B) 80% of cost of major services
- C) 50% of cost of fixed prosthodontics
- D) 50% of cost of orthodontic services

The annual maximum reimbursement of A + B + C = \$2000 per person per calendar year.

The annual maximum reimbursement of D = \$3000 per person lifetime.

Single	\$ 58.26	per month
Family	\$ 147.73	per month

Please note: family includes an eligible spouse and dependent children. Dependent, unmarried children are covered up to the age of 21 or age 25 if in full time attendance at a bona fide educational school.

To Enroll

Please complete the attached forms.

For further information contact the Benefits Department at the C.E.C. at 905-890-070, Extension 24205.

**BENEFITS CHART
DUFFERIN-PEEL C. D. S. B. – BENEFITS DEPARTMENT**

BENEFITS WHILE ON: Certified Supply **Date:** _____

Name: _____ **Employee Number:** _____

Method of Payment: All premiums are paid through the "Pre-authorized Payment Program". To initiate this process **you must complete and sign both sides of this form** and attach your personal cheque marked "VOID".

Please note that only one bank record can be maintained in our system. If you work for Dufferin-Peel on a casual or supply basis the same bank information used for your salary payments must be used for benefits premium payments.

Please return this chart duly completed with your VOID cheques to the Benefits Department, The Dufferin-Peel CDSB, 40 Matheson Blvd., Mississauga, L5R 1C5. For inquiries please call 905-890-0708, extension 24205.

Please commence the benefits I have elected below. I understand that I am responsible for the payment of benefit premiums.

<u>BENEFIT</u>	<u>MONTHLY PREMIUM</u>	<u>ENROLL:</u>	
		<u>Single</u>	<u>Family</u>
Semi-Private Hosp. Single \$15.88 – Family \$53.76	_____	_____	_____
Major Medical Single \$61.14 – Family \$190.04	_____	_____	_____
Dental Single \$58.26 – Family \$147.73	_____	_____	_____
Total Monthly Premium:	_____		

Date: _____

Signature _____

(see over)

DUFFERIN-PEEL CATHOLIC DISTRICT SCHOOL BOARD

Pre-Authorized Payment Authorization Form

Name _____ Employee ID _____

Address _____

City _____ Prov _____ Postal code _____

Bank or Financial Institution _____

Branch Address _____

Transit Number

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Bank Number

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Account Number

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I hereby authorize a debit to my/our account indicated above each month for all payments payable to The Dufferin-Peel Catholic District School Board. Your treatment of each payment shall be the same as if I/we had personally issued a cheque authorizing you to pay as indicated and to debit the amount specified to my/our account. This authorization may be cancelled at any time upon written notice by me/us. Any delivery of this authorization to you constitutes delivery by me/us.

Date _____ Signature _____ Signature _____

For a joint account, all depositions must sign if more than one signature is required on cheques issued against the account.

Please attach a sample-personalized cheque marked "VOID"

**Benefit Premium Withdrawal Dates
for 2007/2008**

Month	Withdrawal Date
July	July 12 th
August	August 23 rd
September	September 20 th
October	October 4 th
November	November 1 st
December	December 13 th
January	January 10 th
February	February 7 th
March	March 6 th
April	April 3 rd
May	May 1 st
June	June 12 th
July	July 10 th
August	August 21 st

Please keep these dates for your reference.