

Enrolment Form

Instructions: The **Enrolment Form** must be completed and signed by your school board(s) each time you sign a contract of employment or the first occasion of substitute teaching in Saskatchewan. If you have a change in your personal information, contract status and/or dependant information, please complete an **Information Change Form**, which is available at www.stf.sk.ca.

Return completed form to:
STF Members' Health Plan
PO Box 1944 Stn Main
Saskatoon SK S7K 3S5

The yellow copy will be forwarded to the Teachers' Superannuation Commission on your behalf.

To be completed by School Division		Contract Status – Check (✓) all that apply	Contract Commencement Date (DD MM YY)	Contract End Date (DD MM YY)
Pension Plan Membership: <input type="checkbox"/> STRP <input type="checkbox"/> TSC <input type="checkbox"/> Superannuate	School Division Name	<input type="checkbox"/> Continuing	D D M M Y Y	Not applicable
School Division Signature		<input type="checkbox"/> Temporary	D D M M Y Y	D D M M Y Y
Date Teacher meets plan eligibility requirements		<input type="checkbox"/> Replacement	D D M M Y Y	D D M M Y Y
20th Teaching Occurrence (DD MM YY)	D D M M Y Y	<input type="checkbox"/> Substitute	Not applicable	Not applicable

Member Information

Last Name: _____ First Name: _____ Initial: _____ Preferred Name: _____

Gender: Male Female Date of Birth (DD MM YY): D | D | M | M | Y | Y Social Insurance Number: _____ Teaching Certificate Number: _____

Home Mailing Address: _____

City: _____ Province: _____ Postal Code: _____ Home Phone: (____) _____

School Name: _____ School Phone: (____) _____

Have you named a beneficiary under your Pension Plan? Yes No, please mail me a form

Dependant Information

To be completed by teachers on a continuing, temporary or replacement contract to enrol eligible dependants in the STF Members' Health Plan and the Teachers' Dental Plan.

Spouse Information

First Name (and Last Name If Different): _____ Date of Birth (DD MM YY): D | D | M | M | Y | Y Gender: Male Female

If your spouse has an Employer Group Plan indicate the coverage provided.

Health: Single Waived Family None Dental: Single Waived Family None
 Vision: Single Waived Family None Drugs: Single Waived Family None

Employer Name: _____ Group Policy Number: _____ Name of Insurance Carrier: _____

If your spouse is a teacher, please provide Member Identification Number: 0 | 1 | 0 | 0 | 0 | _____

Children Information

First Name (and Last Name If Different)	Date of Birth (DD MM YY)	Gender	Full-time Student?*	Mentally or Physically Disabled?
_____	D D M M Y Y	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	D D M M Y Y	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	D D M M Y Y	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	D D M M Y Y	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

*If dependent child is age 21 or older, attach verification of full-time status at educational institution.

Member Authorization

I confirm that the foregoing information is true, complete and accurate as of this date. I consent to the Saskatchewan Teachers' Federation (STF) obtaining, retaining, disclosing, exchanging and using any personal information, including personal health information, about me or my dependants ("information"), at any time, from, to or with others, including STF's affiliates, service suppliers, successors, assigns and other persons, but only for the purpose of furthering or maintaining a current or future relationship between us or between STF and such person, or as may be necessary to determine my or my dependants' entitlement to health, dental, disability, pension and group insurance benefits or any other similar service supplied to me or my dependants by STF, its affiliates or service suppliers. I agree that my consent to the foregoing is a fundamental condition of STF providing certain services to me and my dependants and may not be revoked or withdrawn. I agree to immediately notify STF in writing of any change to the above-listed information.

Member Signature: _____ Date signed (DD MM YY): D | D | M | M | Y | Y



2317 Arlington Avenue
Saskatoon SK S7J 2H8
Phone: (306) 373-1660
Toll Free: 1-800-667-7762
Fax: (306) 374-1122



Teachers'
Superannuation
Commission

300-3085 Albert Street
Regina SK S4S 0B1
Phone: (306) 787-6440
Toll Free: 1-877-364-8202
Fax: (306) 787-1939

The information you provide to us will be used to provide services to you and to determine your entitlement for health, dental, disability, pension and group insurance benefits. Please direct your inquiries as follows:

Dental

- **Teachers' Superannuation Commission**
Toll free 1-877-364-8202 or (306) 787-8814 in Regina

Disability

- **Income Continuance Plan**
Saskatchewan Teachers' Federation
Toll free 1-800-667-7762 or (306) 373-1660 in Saskatoon
- **Saskatchewan Teachers' Superannuation Disability Plan**
Toll free 1-877-364-8202 or (306) 787-6441 in Regina

Health

- **STF Members' Health Plan**
Saskatchewan Teachers' Federation
Toll free 1-800-667-7762 or (306) 373-1660 in Saskatoon

Pension

- **Saskatchewan Teachers Retirement Plan**
Saskatchewan Teachers' Federation
Toll free 1-800-667-7762 or (306) 373-1660 in Saskatoon
- **Saskatchewan Teachers Superannuation Plan**
Teachers' Superannuation Commission
Toll free 1-877-364-8202 or (306) 787-8141 in Regina

Definitions

- **Dependent Information**
For the purposes of the STF Members' Health Plan and the Teachers' Dental Plan only:
 - **Spouse** means your legal spouse, or the person who has cohabited continuously with you in a spousal relationship for at least 12 consecutive months.
 - **Dependent child** means your natural, adopted or step-child who is:
 - under 21 years of age, unmarried, living with you, and solely dependent upon you for support,
 - age 21 or under age 26, dependent upon you for support and in full-time attendance at a university, college, or other educational institution providing courses at a post-secondary level,
 - 21 years of age or older and is incapable of supporting themselves because of physical or mental disability where the disabling condition began
 - before age 21
 - or before age 26 if the child was in full-time attendance at an educational institution and the disabling condition has been continuous since that time.

Ongoing Enrolment Information Required

It is critical to maintain accurate and current records for you and your dependents. If you have a change in your personal information, contract status and/or dependent information please complete an Information Change Form.