



THE UNIVERSITY OF BRITISH COLUMBIA

EMPLOYEE AND FAMILY ASSISTANCE PROGRAM ENROLLMENT FORM

Personal information provided on this form is collected pursuant to section 26 of the Freedom of Information and Protection of Privacy Act, RSBC 1996, c. 165 (FIPPA) for the purposes of benefits administration, claims submission and to make any necessary payroll deductions. The information will be used, retained & disclosed by UBC in accordance with FIPPA. For further information, please email benefitsinfo@hr.ubc.ca.

Name of Employee (first name, last name) Employee Identification Number
Date of Birth (Year, Month, Day) Department Faculty Staff

DEPENDENTS ELIGIBLE FOR COVERAGE:

- 1. Spouse / Common-law spouse / Partner of the same sex
2. Children (age 18 and under, or, between age 19 and age 24 and under) and at full-time attendance at an educational institution recognized by Canada Revenue Agency)
3. Disabled children of any age
4. Dependent parents

Table with 6 columns: Dependent Name, Relationship of Dependent to Employee, Sex (M / F), Date of Birth (YYYY/MM/DD), Indicate if full-time student if over 19 (Y / N), Indicate if disabled (Y / N)

Authorization: As an eligible employee, I hereby enroll those listed above in the UBC Employee and Family Assistance Program.

Signature of Employee Date