CANADIAN BAPTISTS OF ATLANTIC CANADA
Joining God in Our Neighbourhoods

WELCOME TO THE CBAC BENEFITS

Canadian Baptist Pension Plan

- **Canada Life** is the **Canadian Baptist Pension Plan's** record keeper. 6% is to be deducted from your payroll, the employer matches the contribution for a total of 12% to be remitted monthly to Canada Life. You have the option of contributing additional voluntary contributions through your payroll to your account which the church does not match.
- Employees are eligible upon the date of hire or end of probationary period (depending on employment contract)

CBBenefits Group Insurance Plan – must work a minimum of 20 hours/week

- **Canada Life**
  - Basic Life Insurance - $60,000
  - Dependent Life Insurance - $20,000 spouse, $8,000 child
  - Long Term Disability – 67% of your ***reported*** income after 6 months waiting period.
  - Employee and Family Assistance Program – FREE confidential counselling
  - Medical Dental Plan – **This portion can be put on hold IF your spouse has medical dental coverage through his/her employment. All other insurances still apply.**

- **CHUBB**
  - Accidental Death & Dismemberment - $25,000

- **Optional Benefits** are available and will be deducted from your payroll once your **Evidence of Insurability** is approved by Canada Life.
  - Optional Life Insurance – available for member & spouse & child
  - Optional Critical Illness – available for member & spouse
  - Optional Accidental Death & Dismemberment – available for member & family

- Booklets can be found under the insurance tab on our website: https://baptist-atlantic.ca/our-convention/departments/pension-benefits/

YOUR BENEFITS…. YOUR RESPONSIBILITY

Members have only **31 days** to notify your CBAC Pension and Benefits Manager when life changes happen**:**

a) Married – to add spouse to plan and to change name (if needed)
b) Beneficiary changes for any reason
c) Spouse loses medical dental coverage
d) Death of spouse or dependent child
e) Birth or adoption of a child
f) Move – address changes

These situations are the **Members Responsibility** and need your immediate attention when they arise.

Once these forms have been returned to karen.gunn@baptist-atlantic.ca

- You will receive two emails from Canada Life to complete your enrolment into the benefits: one for Medical Dental (Policy 57198 & 160885) and the other for Life insurance, Long Term Disability and Employee and Family Assistance Plan (Policy 156241).
- If you indicate you would like to apply for Optional Coverages, an Evidence of Insurability form will be emailed to you to complete confidentially and sent directly to Canada Life for consideration.
- Your treasurer or Pension and Benefits Manager will provide you with an access ID & password to access www.mycanadalifeatwork.com to enrol into the pension plan.
- **Once enrolled, you can access your benefits on** www.mycanadalifeatwork.com

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EMPLOYEE INFORMATION SUMMARY SHEET

EMPLOYEE NAME: _____

AND STREET NAME: _____

City, Province & Postal Code_____

EMPLOYEE EMAIL ADDRESS: _____

HOME PHONE NUMBER: _____ CELL PHONE NUMBER _____

SOCIAL INSURANCE NUMBER. _____ DATE OF BIRTH: _____ MALE: ☐ FEMALE: ☐

NAME OF CHURCH/ CAMP_____

OCCUPATION TITLE:_____ Pastoral position: ☐ Support position: ☐

Are you: Full-time: ☐ Part-time: ☐ NUMBER OF HOURS A WEEK: _____ (**minimum 20hrs/week**)

ANNUAL SALARY: _____ DATE OF EMPLOYMENT: _____

EFFECTIVE DATE OF COVERAGE:(after probationary period, if applicable) _____

MARITAL STATUS: ☐ Married ☐ Single ☐ Single with Dependents

Applying for Group Insurance: ☐ Yes, all coverage (**must work a minimum of 20 hours/week**)

☐ Yes, but spouse has Med/Dental (**Life, LTD, EFAP, AD&D still apply**)

☐ No, Waiver Form is required (I don't want any insurances)

☐ Not Eligible, I do not work more than 20 hours/week

Applying for Canadian Baptist Pension Plan: ☐ Yes. Online enrolment by treasurer ☐ or CBAC ☐

☐ NO, WAIVER FORM REQUIRED

DATE: _____

APPROVED BY:
CHURCH TREASURER NAME: _____

CHURCH TREASURER EMAIL: _____

Church Treasurer Phone: _____

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CONFIDENTIAL INFORMATION SHEET

Long Term Disability and Pension Calculations

Employee's Name: _____ ID#.: _____
(last 6 digits of S.I.N.)

Effective Date of Salary: _____

TOTAL GROSS SALARY, which includes either:

- Basic Salary PLUS Housing Allowance OR
- Basic Salary PLUS Fair Rental Value of Parsonage AND utilities, if paid by the church on behalf of the member

A. $ _____

 # OF PAY PERIODS (Weekly=52, Bi-weekly=26, Semi-monthly=24, Monthly=12) **B.** _____

PENSION CONTRIBUTION PER PAY PERIOD

- Employee portion -6% deducted from employee. (A divided by B x 6%) **C**. $_____
- Employer portion - 6% matched by the employer. (A divided by B x 6%) **D**. $_____

TOTAL Pension Contribution per Pay Period: (C + D) **E**. $ _____

NOTE: Send in the number of pay periods each month. Ex: If there are 3 pay periods in a month, send in 3 x E.

Pension Contributions are calculated by the Treasurer and sent in **monthly** to the Record Keeper, Canada Life, by the end of the month. It is the record keepers' job to ensure they receive a monthly amount for each member. Canada Life does not verify whether the amount is accurate or not.

Long Term Disability (LTD) Monthly premiums are determined by Canada Life however premiums can roughly be calculated using the following: Total Salary / 12 x .67 x .02707

TREASURER

Church: _____

Treasurer: _____

Email: _____

Phone No: _____ *Date:* _____

Please complete this form and submit to CBAC whenever there is a change in salary or if you have a new employee.

IMPORTANT: *Please return to:* *Karen Gunn, Pension and Benefits Manager*
By email: karen.gunn@baptist-atlantic.ca
Or by mail: PO Box 6003, Moncton, NB E1C 0V7

CANADIAN BAPTISTS OF ATLANTIC CANADA
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OPTIONAL GROUP LIFE QUESTIONNAIRE

Optional Life Member & Optional Life Spouse

Members are encouraged to purchase additional coverage for themselves and\or their spouse. The monthly rates for each 25,000 unit are as follows to a maximum of $500,000:

Age	Male Non-Smoker	Female Non-Smoker
Under 29	$0.75	$0.75
30-34	$1.00	$0.75
35-39	$1.25	$1.00
40-44	$2.25	$1.50
45-49	$3.75	$2.50
50-54	$6.50	$4.50
55-59	$10.25	$7.00
60-64	$15.00	$10.25

☐ **YES**, I wish to apply for **OPTIONAL LIFE** for myself. Number of Units: _____

☐ **YES**, I wish to apply for **OPTIONAL LIFE** for my spouse. Number of Units: _____

☐ **No,** I do NOT wish to apply for **OPTIONAL GROUP LIFE INSURANCE**.

Optional Life Child

Monthly rate per unit of $2,000 to a maximum of $20,000 or 10 units =$0.31

☐ **YES**, I wish to apply for **OPTIONAL LIFE** for my child/children. Number of Units: _____

☐ **No,** I do NOT wish to apply for **OPTIONAL INSURANCE FOR MY CHILD**.

Optional AD&D insurance

Insured	Coverage	Rate
Member Only	$10,000 unit to a maximum of $250,000 or 25 units	$0.20
Spouse	* 40% of member's amount * 50% if no child	$0.30
Child	* 10% of member's amount * 15% if no spouse	$0.30

☐ **YES**, I wish to apply for **OPTIONAL AD&D MEMBER ONLY**. Number of Units: ____

☐ **YES**, I wish to apply for **OPTIONAL AD&D FAMILY.** Number of Units: _____

☐ **No,** I do NOT wish to apply for **OPTIONAL AD&D INSURANCE**.

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OPTIONAL CRITICAL ILLNESS QUESTIONNAIRE

Members and Spouses can apply for Optional Critical Illness which provides a Lump Sum Benefit in the event they are diagnosed with a critical illness. Coverage is available in units of $10,000 to a maximum of $250,000.

Optional Critical Illness (ENHANCED Coverage Only)

Basic Monthly Rates per $1000

	Male	Female		Male	Female
20	0.05	0.05	43	0.30	0.31
21	0.06	0.05	44	0.32	0.33
22	0.06	0.06	45	0.35	0.36
23	0.06	0.06	46	0.38	0.38
24	0.07	0.06	47	0.41	0.41
25	0.07	0.07	48	0.45	0.43
26	0.08	0.07	49	0.49	0.46
27	0.08	0.08	50	0.54	0.49
28	0.09	0.09	51	0.60	0.53
29	0.09	0.09	52	0.66	0.57
30	0.10	0.10	53	0.74	0.62
31	0.11	0.11	54	0.82	0.67
32	0.12	0.12	55	0.93	0.73
33	0.13	0.13	56	1.05	0.79
34	0.15	0.15	57	1.18	0.86
35	0.16	0.16	58	1.31	0.95
36	0.17	0.17	59	1.45	1.03
37	0.19	0.19	60	1.61	1.11
38	0.21	0.20	61	1.78	1.20
39	0.22	0.22	62	1.95	1.31
40	0.24	0.24	63	2.19	1.44
41	0.26	0.26	64	2.43	1.57
42	0.27	0.28			

☐ **YES**, I wish to apply for **OPTIONAL CRITICAL ILLNESS** for **myself**. Number of Units: ____

☐ **YES**, I wish to apply for **OPTIONAL CRITICAL ILLNESS** for **my spouse**. Number of Units: ____

☐ **No,** I do NOT wish to apply for **OPTIONAL CRITICAL ILLNESS INSURANCE**.

Once this questionnaire has been returned and you have indicated that you wish to apply for optional coverage, you will receive a Canada Life Evidence of Insurability form to fill in so that Canada Life can determine whether to grant your request. Therefore, please *DO NOT* forward any premiums until you receive a billing as acceptance of coverage.

NAME: _____

Date: _____