Support Staff Maternity Package

Buffalo Trail PUBLIC SCHOOLS

Buffalo Trail Public Schools

Table of Contents

Central Office Support Staff Human Resources Staff List

Email: hrsupportstaff@btps.ca, all the below staff will receive the notification.

Assistant Superintendent – Human Resources

Mrs. Camille Quinton

(780) 806-2062

Support Staff Payroll and Benefits

Ms. Donna Rozka

(780) 806-2066

Executive Assistant – Human Resources

Mrs. Patti Neale

(780) 806-2048

1041-10A Street

Wainwright, AB T9W 2R4

Phone: (780) 842-6144 Fax: (780) 842-3255

Office Hours: Monday to Friday 8:30 to 4:30

Collective Agreement Article 20 – Maternity and Parental Leave

Article 20 - MATERNITY AND PARENTAL LEAVE

20.01

a) Maternity leave shall be granted without pay upon two (2) weeks' notice.

b) Leave of absence without pay or benefits shall be granted, upon two (2) weeks written notice where possible, to an Employee who is pregnant or who will be the primary caregiver of a natural or adopted child of that Employee. Such leave shall be for a definite period not to exceed sixteen (16) consecutive weeks of maternity leave, sixty-two (62) consecutive weeks for parental (birth or adoption). The Employee agrees to apply for Employment Insurance benefits for maternity or parental leave no later than the date of delivery, in the case of birth, and no later than the date that notice of successful adoption is received by the adopting parent(s), in the case of adoption.

c) The regular Employee returning to work after maternity leave shall provide the Employer with at least two (2) weeks prior notice. On return from maternity leave the regular Employee shall resume her former position or a comparable position.

d) The health-related portion of the Employee's maternity leave shall be as determined by medical documentation. The employer agrees to top up the EI benefits received by the Employee to an amount equal to the Employee's normal weekly earnings, during the health-related portion of the leave, falling within the entitlement period (seventeen 17) weeks maximum).

The Employer agrees that as part of the topping up process, it will pay the full salary for the required EI qualifying period, provided that the Employee does not receive any EI benefits for that period. The provisions of the sick leave article shall not apply in the case of maternity leave. The Employer shall pay its portion of each Employee's benefit plan premium during the health-related portion of her maternity leave. The remainder of the maternity leave not covered by the health-related portion shall be without pay and without Employer contribution to Employee benefit plan premiums or top up of EI benefits. The Employer shall advise each Employee to apply for extended disability benefits at least thirty (30) days in advance of her expected eligibility for such benefit. After ninety (90) consecutive calendar days of disability the Employee shall apply for extended disability benefits and no further salary shall be payable.

Maternity Leave Checklists

Notification of Pregnancy

- ❑ BTPS Support Staff Maternity Package is available on the website under Departments, Human Resources, HR Documents.
- ❑ Support Staff completes Form 1 – Notification and Medical Certification of Pregnancy and forwards to hrsupportstaff@btps.ca as per Article 20 of CUPE Collective Agreement.
  - This form is to advise the employer of your maternity leave requirements and the approximate date of delivery. It also states your estimated return to work.
- ❑ BTPS HR sends a letter of acknowledgment to Support Staff.
  - This letter acknowledges receipt of the request and approves the length of the leave.
- ❑ BTPS Payroll notifies ASEBP that you will be going on leave.
  - Benefit coverage: The Board will continue to pay benefits **during the health-related portion of your leave.** When the health-related portion of your leave is complete, you will be required to pay the total cost of the premiums (both the employee and employer portions) or you can waive them.
  - ASEBP can be contacted directly if you would like further information regarding your options package toll-free at 1-877-431-4786. If you are considering your options we suggest you contact a benefit specialist toll-free at 1-877-438-4545. **Do this as soon as possible.**
  - For administration of benefits and EI top-up, it is important that you return form 3 – Health-Related Portion of Maternity Leave via email hrsupportstaff@btps.ca, **Attn: Support Staff Payroll Officer.** This document is due within **six weeks** of the birth of your baby.

Notification of Sick Leave (Prior to birth of baby)

If there is pregnancy-related sick leave prior to maternity leave:

❑ Support Staff completes Form 2 – Pregnancy-Related Sick Leave and forwards to hrsupportstaff@btps.ca.

- You can submit a doctor's note instead stating the start date of the sick leave and the approximate length of the sick leave.
- Contact the central office support staff HR staff at hrsupportstaff@btps.ca to discuss sick leave and EDB implications.

Note: If pregnancy-related sick leave prior to the birth of your baby is greater than 10 days, your name will be submitted to ASEBP for Extended Disability benefits should your health-related portion after the birth make your total medical leave extend past the 90th day.

❑ Support Staff applies for EI no later than the birth of the baby at: www.servicecanada.gc.ca

- You will be issued a code/password that you must use to access documentation during the EI benefit period.
- Ensure you keep this code/password for future use.

Notification of Birth of Baby

- ❑ Advise BTPS, **Attn: Support Staff Payroll Officer** via phone (780) 806-2066 or email hrsupportstaff@btps.ca ***immediately after the birth*** because EI requires your ROE to be issued within 5 days of the birth.
- ❑ BTPS Payroll will issue the following:
  - ROE for EI purposes is electronically submitted to Service Canada. You can access your copy when you log in to your account.
- ❑ Support Staff completes Form 3 – ASEBP Change Application.

Important: Return this form, **Attn: Support Staff Payroll Officer** via email hrsupportstaff@btps.ca **prior to 31 days from the birth of the baby, otherwise the baby will be considered a late applicant.** Payroll will submit the information electronically to ASEBP.

- ❑ Support Staff completes Form 4 – Health Related Portion of Maternity Leave.
  - It is important to forward this form to BTPS Payroll **as soon as received.** This form determines the health-related portion of maternity leave.
- ❑ Support Staff to submit copies of **First Two EI Payments**.
  - If applying for EI electronically you must print off a copy of your payment detail and submit, **Attn: Support Staff Payroll Officer** via email hrsupportstaff@btps.ca.
  - EI does not mail you a copy when you apply electronically.
  - Double check the dates on your EI payments to ensure that these are the first two.
- ❑ BTPS Payroll will calculate your salary/EI Top-up.
  - The EI top-up will be paid on the next scheduled cheque run, providing all the documentation has been received and is correct.
  - If your baby is born the first part of July, your health-related portion may be over prior to the start of the next school year and there will not be an EI top-up.

Notification of Return to Work

- Support Staff completes Form 5 – Return to Work and forwards to hrsupportstaff@btps.ca no later than 2 weeks prior to your return but preferably 4 weeks prior to your return.
- BTPS HR sends a letter of acknowledgment to the Support Staff.

[redacted]

Example of EI Payments

9:17

srv136.services.gc.ca

Week 1 of reporting period (November 03, 2024 to November 09, 2024)

No benefits were paid as this is a week of your waiting period during which no benefits are payable.

Benefit Rate:	$668
Type of Benefit:	Maternity benefits
Gross Amount:	$0
Tax:	$76
Net Amount Paid:	$0

View next payment details

Date modified: 2024-06-01

- Contact information
- Terms and conditions
- Privacy

[redacted]

[redacted]

Example of EI Payments

Week 1 of reporting period (November 10, 2024 to November 16, 2024)

Benefit Rate:	$668
Type of Benefit:	Maternity benefits
Gross Amount:	$668

Totals for reporting period:

Tax:	$76
Net Amount Paid:	$592

View previous payment details

Date modified: 2024-06-01

- Contact information
- Terms and conditions
- Privacy

[redacted]

BUFFALO TRAIL PUBILC SCHOOLS
NOTIFICATION AND MEDICAL
CERTIFICATION OF PREGNANCY

An employee employed by Buffalo Trail Public Schools who becomes pregnant is entitled to a number of benefits during the health-related portion of her maternity leave. In an effort to fulfill our obligations we require medical certification that the employee is pregnant as well as the expected date of delivery.

SUPPORT STAFF'S NAME: _____

ADDRESS: _____

PART 1: NOTIFICATION OF MATERNITY LEAVE (to be filled out by the support staff)

I am expecting a child approximately _____.

I will be taking 16 weeks of maternity leave and 62 weeks of paternity leave as per clause 20.01 b of the collective agreement, commencing

_____ .

(On a specific date or with the birth of my child)

I wish to return to work on _____.

_____ _____

(Support Staff's Signature) (date)

PART 2: PATIENT INFORMATION AND CONSENT (to be filled out by the support staff)

Are you involved in an ongoing active treatment program with this physician? YES ☐ NO☐

I hereby authorize the release of information outlined on this form to Buffalo Trail Public Schools.

_____ _____

(Support Staff's Signature) (date)

PART 3: PHYSICIAN'S CERTIFICATION (to be filled out by the physician)

PHYSICIAN'S NAME: _____TELEPHONE/FAX: _____

CERTIFIED SPECIALIST: YES ☐ NO☐ SPECIALTY_____

I, _____ hereby certify that_____

(Physician's Name) (Support Staff's Name)

is pregnant with an expected date of delivery of _____.

_____ _____

(Physician's signature) (date)

Revised: November 2024

BUFFALO TRAIL PUBILC SCHOOLS
PREGNANCY-RELATED SICK LEAVE
PRIOR TO THE COMMENCEMENT OF MATERNITY LEAVE

Pregnancy-related sick leave prior to maternity leave is recognized under Buffalo Trail Public Schools sick leave program for support staff. THE INFORMATION THAT WE ARE LOOKING FOR IS CERTIFICATION THAT THE SUPPORT STAFF IS MEDICALLY UNABLE TO ATTEND WORK AND PERFORM HER DUTIES DUE TO HER PREGNANCY.

PART 1: PATIENT INFORMATION AND CONSENT (to be filled out by the support staff)

Are you involved in an ongoing active treatment program with this physician? YES ☐ NO☐

I hereby authorize the release of information outlined on this form to Buffalo Trail Public Schools.

_____ _____

(Support Staff's Signature) (date)

PART 2: PHYSICIAN'S CERTIFICATION (to be filled out by the physician)

PHYSICIAN'S NAME: _____TELEPHONE/FAX: _____

CERTIFIED SPECIALIST: YES ☐ NO☐ SPECIALTY_____

I, _____ hereby certify that_____

(Physician's Name) (Support Staff's Name)

Is/will be MEDICALLY UNABLE TO ATTEND WORK AND PERFORM HER DUTIES DUE TO A PREGNANCY-RELATED ILLNESS as of _____.

(First day of sick leave)

She will be able to return to work on _____

(if earlier than the estimated date of delivery)

OR

She will not be able to return to work until after the birth of the baby.

_____ _____

(Physician's signature) (date)

Form 3

Allendale Centre East
Suite 301, 6104-104 Street NW
Edmonton | Alberta | T6H 2K7
Phone: 1-877-431-4786
www.asebp.ca

CHANGE APPLICATION

INSTRUCTIONS:

1. Please return to your employer within 31 days.
2. If your plan covers Life Insurance and Accidental Death & Dismemberment and you're eligible for them, complete an *Appointment of Beneficiary(ies)* form if, under Section B, you select either option 2, 3, 4, or 5.

A. PERSONAL INFORMATION

Employer name: _____

Last name: _____ First name: _____ ASEBP ID: _____

Employee status: ❑ Working ❑ Leave of absence ❑ Disabled ❑ Other: _____

Previous name (if applicable): _____

Mailing address (including postal code): _____

_____

Phone number (including area code): _____

Email (optional): _____

Date of birth: _____/_____/_____
YYYY MM DD

B. REASON FOR CHANGE

Check off the reason(s) you are requesting a change in your benefits:

❑ 1. Address change
Change date (YYYY/MM/DD): _____

❑ 2. Change in marital status
Change date (YYYY/MM/DD): _____

Type of change: ❑ Marriage/divorce ❑ Other: _____

Are any of your dependants on active duty in any military, naval, or air force, including as a member of the reserves of any country or peacekeeping force? ❑ Yes ❑ No

Note: If yes, coverage under this plan may exclude expenses or claims if incurred when on active duty.

❑ 3. Add common-law spouse/partner
Cohabitation date (YYYY/MM/DD): _____

❑ 4. Birth/adoption/guardianship
Birth/adoption/guardianship date (YYYY/MM/DD): _____

Note: If change is adoption or guardianship, you'll need to provide a copy of the legal guardianship papers to your employer.

❑ 5. Loss of spousal/alternative coverage
Loss date (YYYY/MM/DD): _____

Note: Please include a letter from the employer providing coverage indicating date and reason for termination of benefits.

❑ 6. Other (please explain below)
Event date (YYYY/MM/DD): _____

_____

_____

C. CHANGES IN BENEFITS

Do not complete this section if your reason for change above was an address change.

Select which benefits you need to either add or remove by checking off the appropriate box(es) below. Ensure that you're only selecting one box per row.

Benefit	Add		Remove	
	For myself	For myself and my dependant(s)	Covered under spouse/alternative coverage	Waived/declined
Life, Accidental Death & Dismemberment and Extended Disability Benefits	☐ [1]	n/a	n/a	☐ [2]
Extended Health Care	☐	☐	☐	☐
Dental Care	☐	☐	☐	☐
Vision Care	☐	☐	☐	☐

[1] If selected, you'll be required to complete the *Appointment of Beneficiary(ies)* form as well.

[2] You cannot waive Life, Accidental Death & Dismemberment or Extended Disability Benefits if they are a condition of employment. These benefits are mandatory if you wish to participate in Extended Health Care, Dental Care or Vision Care coverage.

I understand that if any benefits are waived for reasons other than spousal/alternative coverage under another Group Plan, access to certain benefits may, in whole or part, be rejected or restricted for a period of time and subject to medical approval. I agree that, if at a later date I wish to participate in the insurance hereby waived, I may be required to submit, at my own expense, satisfactory evidence of insurability for myself and my dependants for whom the application for coverage is made.

Please sign here only if you are declining or waiving coverage.

Signature: _____ Date: _____

Complete the following only if you wish to terminate all of your benefits with ASEBP.

Termination date (YYYY/MM/DD): _____ at 11:59 p.m.

Signature: _____ Date: _____

D. DEPENDANT INFORMATION

Last name	First name	Relationship	Sex	Date of birth (YYYY/MM/DD)	Benefits (add or remove)

E. DECLARATION OF CONSENT AND AUTHORIZATION

The personal information contained herein is required for the purpose of enrolment in and coverage under the selected ASEBP benefit plans. It may be necessary for ASEBP to disclose some or all of the personal information contained herein to third party service providers or your employer for these purposes. Where third party service providers are retained, appropriate contracts are in place to protect personal information. Personal information disclosed to your employer is restricted to information necessary for administering each group benefit plan you enrolled in.

I understand why the information is required and am aware of the risks and benefits of providing this information. I consent to the collection, use and disclosure of my personal information for the purposes identified above. I understand that I may revoke my consent at any time and acknowledge that doing so will affect my and my dependants' eligibility to receive group benefits.

I understand that by virtue of the provisions of the *Personal Information Protection Act* of Alberta, my dependants are deemed to consent to the collection, use and disclosure of their personal information for the purpose of enrolment in and coverage under the group benefit plans, through me as the applicant.

Your employer and/or ASEBP may elect to copy and/or store this document by secure and reliable digital or other electronic means. By signing this document you agree that this document, including your signature, may be recorded and stored electronically and that any electronic copy of same will be binding upon you to the same extent as the original version.

I agree to the above and declare that my statements in this enrolment application are complete, accurate and true.

Signature: _____ Date: _____

Consent is being obtained in accordance with sections 7, 8, 9 and 61 of the *Personal Information Protection Act* of Alberta and section 1 of the federal *Personal Information Protection Electronic Documents Act*. Be advised that in order to optimize the services we provide we may use service providers outside Canada to carry out certain functions on our behalf. In such situations, we enter into contracts and/or verify that appropriate privacy and security protocols are in place. If you have any questions regarding the collection, use and disclosure of your personal information, please refer to ASEBP's Privacy Policy at www.asebp.ca or contact the privacy officer at 780-438-5300.

F. FOR OFFICE USE ONLY

Date change application received in office	Date of employment	Date eligible for benefits

BUFFALO TRAIL PUBILC SCHOOLS
HEALTH-RELATED PORTION OF MATERNITY LEAVE

The health-related portion of each support staff's maternity leave must be determined by medical documentation. The information we are looking for is the date following the birth of the support staff's child(ren). WHEN THE SUPPORT STAFF COULD MEDICALLY RETURN TO WORK AND PERFORM HER DUTIES.

PART 1: PATIENT INFORMATION AND CONSENT (to be filled out by the support staff)

Are you involved in an ongoing active treatment program with this physician? YES ☐ NO☐

I hereby authorize the release of information outlined on this form to Buffalo Trail Public Schools.

_____ _____
(Support Staff's Signature) (date)

PART 2: PHYSICIAN'S CERTIFICATION (to be filled out by the physician)

PHYSICIAN'S NAME: _____TELEPHONE/FAX: _____

CERTIFIED SPECIALIST: YES ☐ NO☐ SPECIALTY_____

I, _____ hereby certify that_____
(Physician's Name) (Support Staff's Name)

is medically unable to return to work and perform her duties following the birth of her child(ren)

_____ until _____
(date of birth of the baby) (date of return to work)

_____ _____
(Physician's signature) (date)

BUFFALO TRAIL PUBILC SCHOOLS
NOTIFICATION OF RETURN TO WORK

A support staff employed by Buffalo Trail Public Schools who is on maternity/parental leave must give the Board a minimum of two weeks' notice in writing of the day they intend to return to work from their leave.

SUPPORT STAFF'S NAME: _____

ADDRESS: _____

NOTIFICATION OF RETURN TO WORK

As per clause 20.1 c, I will be returning to my position with Buffalo Trail Public Schools on

_____ .

_____ _____

(Support Staff's Signature) (date)