Teacher Maternity Package

Buffalo Trail PUBLIC SCHOOLS

Buffalo Trail Public Schools

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Central Office Teacher Human Resources Staff List

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

Assistant Superintendent – Human Resources

Mrs. Camille Quinton

(780) 806-2062

Teacher Payroll and Benefits

Ms. Pam Peterson

(780) 806-2055

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 11 – Maternity, Adoption, and Parental Leave

11. MATERNITY, ADOPTION AND PARENTAL LEAVE

11.1 Maternity Leave

11.1.1 Upon request, a teacher shall be entitled to maternity leave of absence for a period of up to sixteen (16) weeks commencing within thirteen (13) weeks prior to the estimated due date and no later than the actual date of the birth of the teacher's child.

11.1.2 Maternity leave shall be without pay and benefits except as provided in clause 11.3.

11.1.3 A teacher shall, when possible, give the Employer three (3) months but no less than six (6) weeks written notice of their intention to take a maternity leave. Such notice shall be accompanied by a medical certificate or written statement from a midwife registered with the College of Midwives of Alberta indicating that the teacher is pregnant and giving the estimated date of birth.

11.1.4 The teacher may terminate the health-related portion of the maternity leave at any time with a medical certificate indicating their fitness to return to work. The teacher shall give the Employer no less than four (4) weeks' notice, in writing, of the intended date of return.

11.1.5 Upon expiration of the leave provided pursuant to clause 11.1.1, the teacher shall be reinstated in the position the teacher occupied at the time the leave commenced or in a mutually agreed upon position. In any case, in accordance with the Employment Standards Code and this collective agreement, the teacher will be provided with an alternative position of a comparable nature.

11.2 Parental Leave

11.2.1 Upon request, a teacher shall be entitled to parental leave of absence for the birth or adoption of a child. The leave shall be for a period of up to sixty-two (62) weeks to be taken within seventy-eight (78) weeks of the child's birth or placement in the home.

11.2.2 Parental leave shall be without pay and benefits except as provided in clause 11.3.

11.2.3 The teacher shall give the Employer at least six (6) weeks' written notice of the teacher's intention to take a parental leave. Specifically, in the case of adoption, the teacher will provide as much notice as possible.

11.2.4 The teacher may terminate the leave at any time. The teacher shall give the Employer no less than four (4) weeks' notice, in writing, of the intended date of return.

11.2.5 Upon expiration of the leave provided pursuant to clause 11.2.1, the teacher shall be reinstated in the position the teacher occupied at the time the leave commenced or in a mutually agreed upon position. In any case, in accordance with the Employment Standards Code and this collective agreement, the teacher will be provided with an alternative position of a comparable nature.

11.2.6 If teachers under clause 11.2.1 are parents of the same child, the parental leave granted may be taken by one (1) teacher or shared by both teachers. In any case, the Employer may grant but is not required to grant parental leave to more than one (1) parent of the child at the same time.

11.2.7 **Additional Parental Leave**

a) A teacher, upon request, shall be entitled to an extended parental leave of absence without pay or Employer contributions to the benefits plan for up to six (6) months beyond the maximum parental leave identified in clause 11.2. A teacher will consult with the Assistant Superintendent, Human Resources on the operational context of the school when making this request.

b) The extended leave must commence immediately following parental leave under clause 11.2.

c) Application for such leave must be made no later than three (3) months prior to the commencement of the extended portion of the parental leave.

11.3 Salary Payment and Benefit Premium (Health-Related)

11.3.1 The Employer shall top up Supplementary Employment Benefits (SEB) to one hundred percent (100%) of the teacher's weekly salary for the duration of the health-related portion of the maternity leave at a minimum of six (6) weeks to a maximum of ninety (90) calendar days, or to the extent of sick leave entitlement as per Article 10.

11.3.2 When the teacher is not eligible for Employment Insurance Benefits, the teacher will have access to sick leave benefits as per Article 10.

11.3.3 The teacher shall provide a medical certificate or written statement from a midwife registered with the College of Midwives of Alberta in order to access the SEB plan or sick leave.

11.3.4 The Employer shall pay the portion of the teacher's benefits plan premiums and contribute Health Spending Account (HSA) amounts specified in Article 7.0 of the collective agreement for sixteen (16) weeks of maternity leave.

11.3.5 The Employer shall pay the portion of the teacher's benefits plan premiums specified in Article 7.0 of the collective agreement for thirty-six (36) weeks of parental leave. The Health Spending Account (HSA) will remain active for the duration of parental leave, but no further credits will be contributed to the HSA during this time.

11.4. Benefits – Prepayment or Repayment of Premiums During Unpaid Portion of Leave

11.4.1 Teachers may prepay or repay benefit premiums payable during the duration of parental leave.

11.4.2 Subject to the terms and conditions of the benefits insurance carrier policies, teachers on parental leave may make arrangements through the Employer to prepay one hundred (100) per cent of the benefit premiums for applicable benefits provided for in the existing collective agreement, for a period of up to eighteen (18) months.

11.4.2 Notwithstanding clause 11.3, subject to the terms and conditions of the benefits insurance carrier policies, upon request by the teacher, the Employer will continue paying the Employer portion of the benefit costs for a teacher on parental leave, for the remainder of the parental leave, up to eighteen (18) months, provided the teacher repays the Employer portion of the benefit premiums.

11.4.3 A teacher who commits to clause 11.4.3 is responsible to repay the amount of the Employer paid benefit premiums and shall reimburse the Employer upon return from the leave, in a mutually agreeable, reasonable manner over the period of no more than eighteen (18) months following the teacher's return to duty.

11.4.4 If a teacher fails to return to their teaching duties, the teacher shall be responsible to forthwith repay the Employer paid benefit premiums, and shall reimburse the Employer upon receipt of an invoice.

11.4.5 If a teacher has not fully repaid the cost of benefit premiums previously paid by the Employer under clause 11.4.3 the teacher is not eligible to reapply for additional consideration under clause 11.4.3.

Maternity Leave Checklists

Notification of Pregnancy

- ❑ BTPS Teacher Maternity Package is available on the website under Departments, Human Resources, HR Documents.
- ❑ Teacher completes Form ML 101 – Notification and Medical Certification of Pregnancy and forwards to hrteachers@btps.ca as per Article 11.1.1 of ATA 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.
  - If you choose you may submit your notification by letter/email, but you must include a doctor's certificate (note) stating that you are pregnant with your due date and must also include your estimated return to work date.
- ❑ BTPS HR sends a letter of acknowledgment to the teacher.
  - 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.
  - Continuation of Benefits: Benefit coverage with the Board will remain in effect until the end of the non-health-related leave.
  - For administration of benefits and EI top-up, it is important that you return the form ML 105 – Health-Related Portion of Maternity Leave via email hrteachears@btps.ca, **Attn: Teacher 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:

❑ Teacher completes Form ML 103 – Pregnancy-Related Sick Leave and forwards to hrteachers@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 teacher HR staff at hrteachers@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.

❑ Teacher 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: Teacher Payroll Officer** via phone (780) 806-2055 or email hrteachers@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:
  - Salary payout up to and including the day of baby's birth.
  - ROE for EI purposes is electronically submitted to Service Canada. You can access your copy when you log in to your account.
- ❑ Teacher completes Form ML 104 – ASEBP Change Application.

Important: Return this form, **Attn: Teacher Payroll Officer** via email hrteachers@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.

- ❑ Teacher completes Form ML 105 – 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.
- ❑ Teacher 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: Teacher Payroll Officer** via email hrteachers@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.
  - If you qualify for EDB, ASEBP will top up your EI.

Notification of Return to Work

- ❑ Teacher completes Form ML 106 – Return to Work and forwards to hrteachers@btps.ca no later than 2 weeks prior to your return but preferably 4 weeks prior to your return.
- ❑ BTPS HR sends letter of acknowledgment.

Note: If your return to work is at the start of the next school year and you are considering extending it please reach out to Human Resources via email hrteachers@btps.ca in **April** to help us ensure appropriate staffing.

ATRF: If you are interested in purchasing your service for your Employer Approved Leave please contact ATRF at member@atrf.com or via phone at 1-800-661-9582.

For more information the website is www.atrf.com

[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

A teacher employed by Buffalo Trail Public Schools who becomes pregnant is entitled to several benefits during their maternity leave. In an effort to fulfill our obligations, we require medical certification that the teacher is pregnant as well as the expected date of delivery.

TEACHER'S NAME: _____

ADDRESS: _____

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

I am expecting a child approximately _____.

I will be taking 16 weeks of maternity leave as per clause 11.1 of the collective agreement, commencing _____ .
(On a specific date or with the birth of my child)

I am also requesting parental leave without pay as per clause 11.1.5 of the collective agreement. I wish to return to work on _____.

_____ _____
(Teacher's Signature) (date)

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

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.

_____ _____
(Teacher'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) (Teacher'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 teachers. THE INFORMATION THAT WE ARE LOOKING FOR IS CERTIFICATION THAT THE TEACHER 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 teacher)

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.

_____ _____
(Teacher'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) (Teacher'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)

ML 104 Form

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): _____

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

Email (optional): _____

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 teacher's maternity leave must be determined by medical documentation. The information we are looking for is the date following the birth of the teacher's child(ren). WHEN THE TEACHER COULD MEDICALLY RETURN TO WORK AND PERFORM HER DUTIES.

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

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.

_____ _____
(Teacher'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) (Teacher'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 teacher 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.

TEACHER'S NAME: _____

ADDRESS: _____

NOTIFICATION OF RETURN TO WORK

As per clause 11.1.4 (a) and (b), I will be returning to my teaching position with Buffalo Trail Public Schools on

_____ .

_____ _____

(Teacher's Signature) (date)