



APPLICATION FOR GROUP BENEFITS (HEALTH & DENTAL)

644 MAIN ST PO BOX 220 MONCTON NB E1C 8L3
 7 SPECTACLE LAKE DR DARTMOUTH PO BOX 2200 HALIFAX NS B3J 3C6
 FOR ALL INQUIRIES: TEL 1-800-667-4511 FAX (506) 867-4651

IDENTIFICATION NUMBER: _____

Instructions

- 1 Please print all information in ink.
- 2 Employer to forward original and keep second copy.
- 3) Dependent status: E - Education, if dependent child is attending an accredited school, college or university
 S - Special, if dependent child is physically or mentally disabled

If you now have Medavie Blue Cross Benefits - Please indicate		Application for Benefits		
Policy Number	Identification Number	Coverage Applied For :	Basic Coverage Applied For:	Language Preference
		<input type="checkbox"/> Single <input type="checkbox"/> Family	<input type="checkbox"/> Health <input type="checkbox"/> Dental	<input type="checkbox"/> English <input type="checkbox"/> French

TO BE COMPLETED BY APPLICANT

51 Last Name Address Street & No. City or Town Province Postal Code	52 <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="7" style="text-align: center;">Individual Registration</th> </tr> <tr> <th style="width: 15%;">First Name</th> <th style="width: 5%;">Initial</th> <th style="width: 30%;">Surname (If different from applicant) *</th> <th style="width: 5%;">Sex</th> <th colspan="3" style="width: 20%;">Birth Date</th> <th style="width: 10%;">Dep. Status</th> </tr> <tr> <td></td> <td></td> <td></td> <td>M/F</td> <td>DD</td> <td>MM</td> <td>YY</td> <td></td> </tr> <tr> <td>Employee</td> <td></td> <td></td> <td>00</td> <td></td> <td></td> <td></td> <td>E - Student (College/ University)</td> </tr> <tr> <td>Spouse</td> <td></td> <td></td> <td>01</td> <td></td> <td></td> <td></td> <td>S - Disabled</td> </tr> <tr> <td>Children</td> <td></td> <td></td> <td>02</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td>03</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td>04</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td>05</td> <td></td> <td></td> <td></td> <td></td> </tr> </table>	Individual Registration							First Name	Initial	Surname (If different from applicant) *	Sex	Birth Date			Dep. Status				M/F	DD	MM	YY		Employee			00				E - Student (College/ University)	Spouse			01				S - Disabled	Children			02								03								04								05				
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* IF APPLICANT AND SPOUSE ARE NOT LEGALLY MARRIED, PLEASE PROVIDE COMMENCEMENT DATE OF CO-HABITATION. _____

COORDINATION OF BENEFITS

Do you or any of your dependents have other coverage under any other Insurer? Yes No **If Yes, complete the following:**

Name of the Other Insurer: _____ Effective Date of Coverage: _____

Identification Number/Certificate Number: _____ Policy Number: _____

Is the Coordination of Benefits Single Coverage or Family Coverage? Please indicate under "Type of Coverage" S for Single or F for Family for the applicable benefits.

Type of Coverage: All _____ Hospital _____ Extended Health Benefits _____ Vision _____ Drugs _____ Dental _____

WAIVER OF BENEFITS -I have been given the opportunity to apply for coverage but do not wish to participate, and understand that I will not be able to enrol in these plans at a later date without the mutual consent of my employer and Medavie Blue Cross.

Waive Only _____ Reason _____

Waive all Benefits _____

Employee Signature _____ Date _____

I certify that all information contained hereon is correct and hereby authorize payroll deductions, if required. I authorize Blue Cross to collect, use and disclose my personal information as described on the reverse.

Employee Signature _____ Date _____

TO BE COMPLETED BY EMPLOYER

70 Name of Employer			Policy and Section Number			Class of Coverage - Health and/or Dental		
Occupation			Coverage Effective Date			DD	MM	YY
<input type="checkbox"/> Permanent Date Employed		Hours Worked / Week	<input type="checkbox"/> Payroll No. (maximum 9 positions)		Completed for Employer by			
DD	MM		YY	1				
			2	Signature _____				Date _____

PRIVACY STATEMENT

I understand that the personal information provided herein, as well as any other personal information currently held or collected in the future by Medavie Blue Cross and/or Blue Cross Life Insurance Company of Canada, may be collected, used, or disclosed to administer the terms of my policy or the group policy of which I am an eligible member, to recommend suitable products and services to me*, and to manage Blue Cross's business. Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These third parties include other Blue Cross organizations, health care professionals or institutions, life and health insurers, government and regulatory authorities, and other third parties when required to administer and manage the benefits outlined in the policy of which I am an eligible member.

I understand that my personal information will be kept confidential and secure.

I understand that I may revoke my consent at any time, however, in some instances doing so may prevent Blue Cross from providing me with the requested coverage or benefits. I understand why my personal information is needed and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure.

A photocopy of this authorization shall be as valid as the original. This consent complies with federal and provincial privacy laws. For additional information regarding privacy policies at Medavie Blue Cross, visit www.medavie.bluecross.ca or call 1-800-667-4511.

*not applicable in Ontario or Quebec