MEDAVIE BLUE CROSS™

www.medavie.bluecross.ca

GROUP BENEFITS APPLICATION
Health, Dental, Life & Disability

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TEL: 1-888-588-1212
FAX: 1-514-286-8444

Identification / Certificate Number: ____________________

(If you are part of a payroll policy, please provide payroll number above.)

1 TO BE COMPLETED BY THE EMPLOYER

Employer Name: ____________________

Policy Number: ____________ Division Number: ____________ Class: ____________

Permanent Date Employed: ____________ (DD/MM/YYYY) Eligible Date of Coverage: ____________ (DD/MM/YYYY)

Occupation: ____________ Job Title: ____________

Number of hours worked per week: ________ Salary (before deductions): ________ ❍ Annual ❍ Monthly ❍ Weekly ❍ Hourly

Employment Type: ❍ Full Time Hourly ❍ Part Time Hourly ❍ Full Time Salary ❍ Part Time Salary

2 EMPLOYEE AND CONTACT INFORMATION

First Name: ____________ Last Name: ____________

Gender: ❍ Male ❍ Female Birth Date: ____________ (DD/MM/YYYY)

Mailing Address: ____________ Apt. Number: ________

City/Town: ____________ Province: ____________ Postal Code: ________

Telephone Number: ____________ Email Address: ____________

Language: ❍ English ❍ French

3 OTHER FAMILY INFORMATION

First Name	Last Name	Date of Birth (DD/MM/YYYY)	Gender M/F	Relationship	Dependent Status (S - College/University D - Disabled)

If applicant and spouse are not legally married, please provide commencement date of co-habitation (DD/MM/YYYY): ____________

Please provide family information in order to have the Dependent Life benefit, if eligible.

4 OTHER COVERAGE

I have been given the opportunity to apply for coverage but do not wish to participate. I 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. Also, I may be required to submit medical evidence of insurability at that time.

I do not want to participate in the following coverage**:** ❍ Health ❍ Dental ❍ Both Health and Dental

Additional Comments: ____________________

For Québec Residents: Participation in the Health coverage plan can only be declined due to spousal coverage. If declining the Health coverage, please complete your spouse's coverage information.

Spouse's Insurer: ____________ Policy Number: ____________ ID/Certificate Number: ____________

5 BASIC COVERAGE (please select benefits available to you per your contract/booklet)

The dependent information must be provided within the "Other Family Information" section above in order to be given the Dependent Life benefit.

❍ Health ❍ Dental ❍ Member Life ❍ Accidental Life & Dismemberment ❍ Dependent Life

❍ Short Term Disability ❍ Long Term Disability ❍ Critical Illness

Health / Dental Coverage: ❍ Employee Only ❍ Employee & Spouse ❍ Employee, Spouse & Family ❍ Single Parent (Québec only)

6 OPTIONAL COVERAGE (please select benefits available to you per your contract/booklet)

If applying for Optional Coverage, the Non-Smoker Questionnaire and/or the Statement of Health may also be required.

Optional Life: ❍ Employee Only Employee Amount $ ____________
❍ Spouse Only Spouse Amount $ ____________
❍ Employee & spouse

Optional Accidental Death & Dismemberment: ❍ Employee Only ❍ Employee & Family Amount $ ____________

Optional Dependent Child Life: ❍ Yes ❍ No Amount $ ____________

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Blue Cross Life Insurance Company of Canada underwrites all life and disability income benefits.

FORM-894E 02/15

7 BENEFICIARY

With the exception of an irrevocable designation, you may change your beneficiary at any time without his or her consent.

By choosing irrevocable, no future changes to the designated beneficiary(ies) will be permitted without the written consent of that beneficiary(ies) when the beneficiary(ies) is/are of the age of majority under the provincial jurisdiction of residence.

For the Province of Québec, the designation of your spouse as beneficiary is presumed irrevocable unless otherwise specified.

Benefits are paid to the designated beneficiary(ies) below. If a legal beneficiary has not been appointed and the below fields are left blank, benefits are paid to the estate of the deceased employee.

First Name	Last Name	Date of Birth (DD/MM/YYYY)	Percentage (Must total 100%)	Relationship	Telephone Number	Revocable	Irrevocable
						❍	❍
						❍	❍
						❍	❍
						❍	❍

Trustee and Contingent Information:

Trustee: A person given control or powers of administration of property held in trust with a legal obligation to administer it solely for the purposes specified. For designated beneficiaries considered a minor, a Trustee is to receive any amount due for any beneficiary considered a minor under the provincial jurisdiction of residence.

Contingent: The individual(s) designated by the Employee to receive benefits in the event the primary beneficiary is deceased.

	First Name	Last Name	Date of Birth (DD/MM/YYYY)	Relationship	Telephone Number
Trustee					
Contingent					

For the Province of Québec, where the beneficiary of a life insurance policy is a minor at the time of the insured's death, Medavie Blue Cross will pay the proceeds to parent(s) (or other legal guardian, if applicable), and not to anyone else who might be named as administrator/trustee of the proceeds. If you wish to have another person administering the child's proceeds, you should have the proper provisions in your will. You may also want to consult with a legal counsel to determine whether there is some estate planning steps you can take to support your wishes.

8 COORDINATION OF BENEFITS

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

Who is the owner of the other plan? ____________ Name of the Insurance Carrier: ____________

Effective Date of Coverage (of other plan): ____________ (DD/MM/YYYY) Policy Number: ____________

ID/Certificate Number: ____________ Type of Coverage: ❍ Hospital ❍ Vision ❍ EHB ❍ Drugs ❍ Dental ❍ All

Who is insured under other plan?

First Name	Last Name	Date of Birth (DD/MM/YYYY)	Relationship

9 DIRECT DEPOSIT

I request that my benefits be paid through Electronic Funds Transfer (Direct Deposit) ❍ Yes ❍ No
(If yes is selected, please include a void cheque in your name and/or complete the banking information below.)

I may cancel this authorization at any time by giving 30 days written notice to Medavie Blue Cross.

Bank Name/Address ____________

Branch number ____________ Bank Account number ____________

10 PRIVACY CONSENT

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.

11 PRESCRIPTION DRUG INSURANCE (QUEBEC ACT)

All persons under 65 years of age who have access to a group insurance plan must enrol in the plan unless they already participate in another group plan or have insurance under a spouse's group plan. Proof of coverage must be kept on file with the employer.

By enrolling in your employer's group insurance plan, you are required to also arrange for coverage for all eligible dependents unless they are already covered under another group insurance plan.

Your dependents do not qualify for coverage under the RAMQ's basic prescription drug insurance plan if you already have coverage under an employer's group plan with the exception of a spouse aged 65 years or over.

When you complete your income tax return, you will be asked to confirm that you have complied with the provisions of the Act.

12 AUTHORIZATION

I certify that the information above is accurate and authorize payroll deductions, if required. I authorize Blue Cross to collect, use and disclose my personal information as described in the Privacy Consent section above.

Employee Signature: ____________ Date: ____________ (DD/MM/YYYY)

Employer Signature: ____________ Date: ____________ (DD/MM/YYYY)