MEDAVIE BLUE CROSS™

APPLICATION FOR GROUP BENEFITS
(HEALTH & DENTAL)

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

Instructions
1. Please fill in ALL required Fields.
2. 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	
Policy Number	Identification Number

APPLICATION FOR BENEFITS

Coverage Applied for ❑ Single ❑ Family	Basic Coverage Applied For ❑ Health ❑ Dental
Language Preference ❑ English ❑ French	

TO BE COMPLETED BY APPLICANT

Last Name						
Address Street & No.						
City or Town	Province	Postal Code				
Telephone Number (Please include area code)						

INDIVIDUAL REGISTRATION

	MEMBER					
First Name	Initial	Birth Date	DD	MM	YY	
	Sex ❑ Male ❑ Female					
	SPOUSE					
First Name	Initial	Birth Date	DD	MM	YY	
Surname (If different from member*)	Sex ❑ Male ❑ Female					
*** if member and spouse are not legally married, please provide commencement date of co-habitation**			DD	MM	YY	
	CHILDREN					
First Name	Initial	Birth Date	DD	MM	YY	
Surname (If different from member*)	Sex ❑ Male ❑ Female					
Dependent Status ❑ E – Student (College/University) ❑ S – Disabled						
	CHILDREN					
First Name	Initial	Birth Date	DD	MM	YY	
Surname (If different from member*)	Sex ❑ Male ❑ Female					
Dependent Status ❑ E – Student (College/University) ❑ S – Disabled						

CHILDREN						
First Name	Initial	Birth Date	DD	MM	YY	
Surname (If different from member*)	Sex ❑ Male ❑ Female					
Dependent Status ❑ E – Student (College/University) ❑ S – Disabled						

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	DD	MM	YY	
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	❑ Waive all Benefits				
Reason					
Employee Signature	Date	DD	MM	YY	

I authorize Blue Cross to collect, use and disclose my personal information.

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

I have read the above statement and would like to apply for coverage ❑	Date	DD	MM	YY	

TO BE COMPLETED BY ADMINISTRATOR

Name of Association					Policy and Section Number				
Class of Coverage – Health and/or Dental					Coverage Effective Date	DD	MM	YY	
Occupation					Hours worked / Week				
Date of membership	DD	MM	YY		Payroll No.				
Submitted Electronically on	DD	MM	YY						
Identification Number									