MEDAVIE BLUE CROSS™

GROUP BENEFITS APPLICATION
Health, Dental, Life & Disability

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1 TO BE COMPLETED BY THE EMPLOYER

Name of Employer: _____

Policy Number: _____ Division Number: _____ Class: _____

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

Employee Payroll Number (if applicable): _____ Occupation/Job Title: _____

Province of Employment: _____ Number of hours worked per week: _____

Salary (before deductions): _____ Frequency: ☐ Annual ☐ Monthly ☐ Weekly ☐ Bi-Weekly ☐ Hourly

Employment Type: ☐ Full Time Hourly ☐ Part Time Hourly ☐ Full Time Salary ☐ Part Time Salary ☐ Contract/Temporary

2 EMPLOYEE AND FAMILY INFORMATION

Employee Last Name: _____ Employee First Name: _____

Gender: ☐ Male ☐ Female Date of Birth (DD/MM/YYYY): _____

Address (Street & Number): _____

City/Town: _____ Province: _____ Postal Code: _____

Telephone Number: _____ Language Preferred: ☐ English ☐ French

Are all members of your immediate family eligible and enrolled with your provincial health plan such as OHIP, MSI, Pharmacare, Medicare etc.?
☐ Yes ☐ No

Spouse (if applicable)

Last Name: _____ First Name: _____

Gender: ☐ Male ☐ Female Birth Date (DD/MM/YYYY): _____

Status: ☐ Married ☐ Common-Law Date of co-habitation if common-law (DD/MM/YYYY): _____

Dependent Children (if applicable)

First Name	Last Name	Date of Birth (DD/MM/YYYY)	Gender M/F	Dependent Status
			☐ Male ☐ Female	☐ Disabled ☐ Student - College/University
			☐ Male ☐ Female	☐ Disabled ☐ Student - College/University
			☐ Male ☐ Female	☐ Disabled ☐ Student - College/University

OTHER COVERAGE (CO-ORDINATION OF BENEFITS)

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

Name of the Other Insurer: _____ Effective Date of Coverage (DD/MM/YYYY): _____

Policy Number: _____ ID Number: _____ **Type of Coverage:** ☐ Hospital ☐ Vision ☐ EHB ☐ Drugs ☐ Dental ☐ All

Name of Employer: _____

Name of Person(s) insured under other policy	Date of Birth DD	MM	YYYY

Name of Person(s) insured under other policy	Date of Birth DD	MM	YYYY

3 WAIVER OF 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 have been given the opportunity to apply for coverage. I do not wish to participate and waive this offer due to spousal coverage. I understand that I may be required to submit medical evidence of insurability should I apply 31 days after losing spousal coverage.

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

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.

4 BASIC COVERAGE (PLEASE CONFIRM APPLICABLE BENEFITS WITH YOUR GROUP ADMINISTRATOR)

If eligible, the Dependent Life benefit will be provided automatically if the dependent information is provided within Section 2 - Other family information or Section 6 - Beneficiary.

☐ Health ☐ Dental ☐ Member Life ☐ Accidental Death & Dismemberment ☐ Dependent Life

☐ Short Term Disability ☐ Long Term Disability ☐ Critical Illness ☐ HCSA Allocation $ _____

Health / Dental Coverage: ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Family ☐ Single Parent

5 OPTIONAL COVERAGE (PLEASE CONFIRM APPLICABLE BENEFITS WITH YOUR GROUP ADMINISTRATOR)

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

Optional Life: ☐ Employee Employee Amount $ _____ ☐ Spouse Spouse Amount $ _____

Optional Dependent Child Life: Amount $ _____

Optional Critical Illness: ☐ Employee Employee Amount $ _____ ☐ Spouse Spouse Amount $ _____

☐ Child Child Amount $ _____

Optional Accidental Death & Dismemberment: ☐ Employee Only ☐ Employee & Family Amount $ _____

6 BENEFICIARY

Any beneficiary(ies) designated below may be revocable or irrevocable at your choice.

- A revocable designation can be changed at any time by completing and submitting a new designation form;
- An irrevocable designation requires the written consent of the named irrevocable beneficiary in order to remove their name as beneficiary and/or change the allocation amount (%). The beneficiary must be of the age of majority under the provincial jurisdiction of residence to provide the written consent.

If the beneficiary designation is not specified, it will be considered revocable by default, with the exception of the Province of Quebec, the beneficiary designation of a spouse is irrevocable by default, unless revocable is specified below.

Benefits are paid to the designated beneficiary(ies) below. If a legal beneficary 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	Revocable	Irrevocable
					☐	☐
					☐	☐
					☐	☐
					☐	☐

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)	Percentage (Must total 100%)	Relationship	Telephone Number
Contingent						
Contingent						

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.

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

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.

7 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 visit our website at medaviebc.ca.

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

8 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 medaviebc.ca or call 1-800-667-4511.

9 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): _____

10 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.