



APPLICATION FOR GROUP BENEFITS (HEALTH, DENTAL, LIFE & DISABILITY INCOME)

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: _____

TO BE COMPLETED BY EMPLOYEE

51 Last Name		52 First Name		Sumame, if different from employee *	Sex M/F	Birth Date			Dependent Status
		Initial				DD	MM	YY	
Address - Street & No.		Employee			00				E - Student College/University S - Disabled
		Spouse			01				
		Children			02				
City or Town		Province			03				
Postal Code		Telephone			04				
		()			05				

* 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 _____

BASIC COVERAGES APPLIED FOR

Life AD & D Dependent Life Health Dental
 Weekly Indemnity Critical Conditions Long Term Disability

53 Health / Dental Coverage: Single Family Language Preferred: English French

OPTIONAL LIFE (Complete Statement of Health form for coverage)

Employee Only Spouse Only Employee & Spouse
Employee Amount \$ _____ Spouse Amount \$ _____

OPTIONAL AD & D

Employee Only Employee & Family Employee Amount \$ _____
For Dependent Life, Critical Conditions, Optional Life and Optional AD & D, the employee is the beneficiary of the insured spouse and children.

BENEFICIARY'S LAST NAME	FIRST NAME	INITIAL	RELATIONSHIP	PERCENTAGE
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____

For designated beneficiaries under the age of 18: I appoint _____ as Trustee to receive any amount due for any beneficiary considered a minor under the Provincial jurisdiction of residence.

WAIVER OF BENEFITS - 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.

Waive Only _____ Reason _____
 Waive all Benefits _____

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 Statement on the reverse of this form.

Employee Signature _____ Date _____

TO BE COMPLETED BY EMPLOYER

54 Name of Employer			Policy and Section Number			Class of Coverage -Health and/or Dental					
Employee Class - Life and/or Disability Income			Occupation			Coverage Effective Date DD MM YY					
<input type="checkbox"/> Permanent Date Employed DD MM YY			<input type="checkbox"/> Complete for Life and Disability Income Benefits Earnings Per <input type="checkbox"/> Hour <input type="checkbox"/> Month \$ _____ <input type="checkbox"/> Week <input type="checkbox"/> Year			<input type="checkbox"/> Hours Worked/Week <input type="checkbox"/> Payroll No. (maximum 9 positions) 1 _____ 2 _____			Completed for employer by 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