MEDAVIE BLUE CROSS™

GROUP BENEFITS APPLICATION
Including Optional Benefits

644 MAIN ST PO BOX 220
MONCTON NB E1C 8L3
TEL: 1-800-667-4511 FAX: 1-506-869-9653
maax.policy.administrators@medavie.bluecross.ca

230 BROWNLOW AVE DARTMOUTH
PO BOX 2200 HALIFAX NS B3J 3C6
TEL: 1-800-667-4511 FAX: 1-506-869-9653
maax.policy.administrators@medavie.bluecross.ca

PO BOX 2000, 185 THE WEST MALL SUITE 1200
ETOBICOKE ON M9C 5P1
TEL: 1-800-355-9133 FAX: 1-506-869-9653
maax.policy.administrators@medavie.bluecross.ca

1981 MCGILL COLLEGE AVENUE, SUITE 100
MONTREAL, QC H3A 3A7
TEL: 1-888-588-1212 FAX: 1-514-286-8444
administration@medavie.bluecross.ca

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): _____

Occupation/Job Title: _____

Employee Payroll Number (if applicable): _____ Province of Employment: _____

Number of hours worked per week: _____ Salary (before deductions): _____ Frequency: ☐ Annual ☐ Monthly ☐ Weekly ☐ Bi-Weekly ☐ Hourly

HCSA Allocation $ (if applicable): _____ PSA Allocation $ (if applicable): _____

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

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

2 EMPLOYEE AND FAMILY INFORMATION

Employee First Name: _____ Employee Last Name: _____

Gender: ☐ Male ☐ Female Language Preferred: ☐ English ☐ French Date of Birth (DD/MM/YYYY): _____

Address (Street & Number): _____

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

Telephone Number: _____ Employee E-mail Address: _____

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

Spouse (if applicable)

First Name: _____ Last 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

If eligible, the Dependent Life benefit will be provided automatically if the dependent information is provided within this section or Section 5 - Beneficiary.

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:
☐ **Health** - ☐ Single ☐ Family ☐ Single Parent ☐ Employee and Spouse
☐ **Dental** - ☐ Single ☐ Family ☐ Single Parent ☐ Employee and Spouse

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3 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.

Do you use tobacco products? ☐ Yes ☐ No
Answer "No" if you have not used any nicotine or used any smoking cessation products in any form (including e-cigarettes) in the past 12 months.

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 $ _____

4 WAIVER OF COVERAGE

All benefits under your group insurance plan are mandatory and provided to you based on the group contract. However, you may waive the health and dental benefits if you have similar coverage under your spouse/common-law partner's plan.

☐ 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 understand that should I lose spousal coverage, and do not apply for coverage under this policy within 31 days of losing spouse/common-law partner plan, I may be required to submit medical evidence of insurability to apply for coverage under this policy after the afore mentionned period of 31 days.

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.

5 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.

Primary Beneficiary(ies)

First Name	Last Name	Date of Birth (DD/MM/YYYY)	Percentage (Must total 100%)	Relationship

Contingent Beneficiary(ies): 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
Contingent Beneficiary(ies)					
Contingent Beneficiary(ies)					

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
Trustee				

Note: Where Quebec law applies and you have designated your married spouse or civil union spouse as beneficiary, the designation will be irrevocable unless you check the box marked "Revocable". I hereby make the above beneficiary designation: ☐ Revocable Beneficiary

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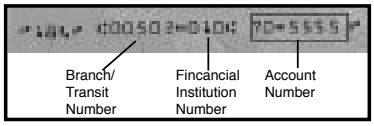
6 DIRECT DEPOSIT

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



Name(s) of Account Holder
(as it appears on the cheque) : _____

Name of Financial Institution: _____

Address of Financial Institution: _____

Financial Institution Number (3 digits): _____ Branch/Transit Number (5 digits): _____

Account Number (7 - 14 digits): _____ (If your Account Number starts with a zero, be sure to include the zero. Do not Include dashes, hyphens or any other punctuation.

7 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.

8 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 Name (please print): _____

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

9 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 a lready 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.

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