MANITOBA BLUE CROSS®

P.O. BOX 1046, WINNIPEG, MANITOBA R3C 2X7
TEL: (204) 775-0161 FAX (204) 774-1761

THE PROVINCE OF MANITOBA
APPLICATION FOR GROUP BENEFITS

THIS SECTION TO BE COMPLETED BY EMPLOYEE

SURNAME	GIVEN NAME AND MIDDLE INITIAL(S)	EMPLOYEE DATE OF BIRTH:	DAY	MONTH	YEAR

ADDRESS- STREET/BOX NUMBER	CITY OR TOWN	PROVINCE	POSTAL CODE

TELEPHONE NUMBER HOME ( )	WORK ( )	GENDER ☐ MALE ☐ FEMALE	PROVINCIAL HEALTH NUMBER

PLEASE COMPLETE THIS SECTION IF YOU HAVE ELIGIBLE DEPENDENTS

☐ SPOUSE ☐ COMMON LAW	SURNAME (IF DIFFERENT THAN EMPLOYEE'S)	GIVEN NAME AND MIDDLE INITIAL	DATE OF BIRTH DAY	MONTH	YEAR	GENDER ☐ MALE ☐ FEMALE

IF APPLICANT AND SPOUSE ARE NOT LEGALLY MARRIED PLEASE PROVIDE COMMENCEMENT DATE OF COHABITATION_____

UNMARRIED DEPENDENT CHILDREN:

SURNAME (IF DIFFERENT THAN EMPLOYEE)	GIVEN NAME AND MIDDLE INITIAL	RELATIONSHIP	DATE OF BIRTH DAY	MONTH	YEAR	GENDER
						☐ M ☐ F
						☐ M ☐ F
						☐ M ☐ F
						☐ M ☐ F

COVERAGES APPLIED FOR

☑ AMBULANCE AND HOSPITAL	☑ PRESCRIPTION DRUGS	☑ DENTAL SERVICE PLAN	☑ VISION CARE PLAN	☐ HEALTH SPENDING ACCOUNT

- **EMPLOYEES MUST ENROLL ACCORDING TO THEIR TRUE FAMILY STATUS**
- **ONCE ENROLLED, EMPLOYEES MAY NOT OPT OUT WHILE STILL EMPLOYED (EXCEPT IN THE EVENT OF DUPLICATE GROUP COVERAGE)**

DO YOU HAVE COVERAGE FOR ANY OF THE BENEFITS APPLIED FOR THROUGH ANOTHER INSURANCE PLAN? ☐ NO ☐ YES – **IF YES PLEASE INDICATE:**

BENEFITS COVERED ☐ HEALTH ☐ VISION ☐ DENTAL ☐ DRUGS	NAMES OF INSURED	NAME OF INSURANCE COMPANY	POLICY NUMBER

PLEASE COMPLETE THIS SECTION IF YOU ARE WAIVING BENEFITS

I AM WAIVING THE FOLLOWING BENEFITS AS I AM CURRENTLY COVERED THROUGH MY SPOUSE'S PLAN: ☐ HEALTH ☐ DENTAL ☐ VISION

POLICY NUMBER	NAME OF INSURANCE COMPANY

I CERTIFY THAT ALL THE ABOVE INFORMATION IS CORRECT AND I AGREE TO THE CONDITIONS OF THE GROUP AGREEMENT BETWEEN MY EMPLOYER AND MANITOBA BLUE CROSS. I ALSO AGREE TO THE AUTHORIZATION AND CONSENT ON THE REVERSE SIDE OFTHIS FORM.

EMPLOYEE SIGNATURE:_____ **DATE**:_____

THIS SECTION IS TO BE COMPLETED BY EMPLOYER

NAME OF GROUP **THE PROVINCE OF MANITOBA**	GROUP NUMBER	DATE OF HIRE ☐ FULL TIME	DAY	MONTH	YEAR

EMPLOYEE NUMBER	OCCUPATION	HOURS WORKED/WEEK	☐ PART TIME			

I HEREBY CERTIFY THIS EMPLOYEE MEETS THE CONTRACTUAL REQUIREMENTS OF BEING AN ELIGIBLE EMPLOYEE	COMPLETED FOR EMPLOYER BY	DATE	TELEPHONE

BLUE CROSS USE ONLY

GROUP NUMBER	**ROLL**	**COVERAGE EFFECTIVE**			**CONTRACT NUMBER**
		DAY	**MONTH**	**YEAR**	

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AUTHORIZATION AND CONSENT

I understand that the personal information provided herein as well as any other personal information currently held or collected in the future by Manitoba Blue Cross may be collected, used, or disclosed to administer the terms of the group policy of which I am an eligible member, to develop and recommend suitable products and services to me, and to manage the Company'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 Plans, health care professionals or institutions, health and life insurers, government and regulatory authorities, and other third parties when required to administer the benefits outlined in my policy or the group 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, if consent is withheld or revoked, the coverage may be denied or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding Blue Cross' privacy policies I can contact Blue Cross at 1-800-873-2583 or www.mb.bluecross.ca should I have questions as to the collection, use or disclosure of my personal information.

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