

# GROUP BENEFITS ENROLMENT FORM Including Optional Benefits

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

**Type of Coverage:** O **Health** - O Single

O Dental - O Single

O Family

O Family

O Single Parent

O Single Parent

O Employee and Spouse

O Employee and Spouse

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.policyadministrators@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 EMPLO   | YER                                  |                                   |                    |   |  |
|--|--------------------------------------|-----------------------------------|--------------------|---|--|
| Name of Employer:  |                                      |                                   |                    |   |  |
| Policy Number:   | Division Number:                     | C                                 | 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: O Annual O Monthly O Wee  | kly O Bi-Weekly O Hourly             | ,                                 |                    |   |  |
| HCSA Allocation \$ (if applicable):  |                                      | PWA Allocation \$ (if applie      | cable):            |   |  |
|  |                                      | ime Salary O Part Time Sal        |                    |   |  |
| Employer Signature:  |                                      | Date (DI                          | D/MM/YYYY):        |   |  |
|  |                                      |                                   |                    |   |  |
| 2 EMPLOYEE AND FAMILY INFORMAT   | TION                                 |                                   |                    |   |  |
| Employee First Name:   |                                      | Employee Last Name:               |                    |   |  |
| Sex*: O Male O Female O Intersex O Undisc  | closed Language Prefer               | red: O English O French           | Date of Birt       | h (DD/MM/YYYY):                           |  |
| Address:   |                                      |                                   |                    |   |  |
| City/Town:   | Province:                            | F                                 | ostal Code: _      |   |  |
| Home Telephone Number:   |                                      | _ Cellular Number:                |                    |   |  |
| Employee E-mail Address:   |                                      |                                   |                    |   |  |
| Health / Dental Coverage: O Employee Onl   | ly O Employee & Spouse               | ○ Employee & Family ○ Si          | ingle Parent       |   |  |
| Modular/Flex options (Please indicate your character of the Sex: Male/Female/Intersex/Undisclosed - Why do we ask? Sex: M | Some health conditions are more like |                                   |                    |   |  |
| First Name:  |                                      | Last Name:                        |                    |   |  |
| Sex: O Male O Female O Intersex O Undisclosed  Birth Date (DD/MM/YYYY):  |                                      |                                   |                    |   |  |
| Status: O Married O Common-Law   |                                      | Date of co-habitation if cor      | nmon-law (DD/      | MM/YYYY):                                 |  |
| Dependent Children (if applicable)  First Name   | Last Name                            | Date of Birth                     | Sex<br>M/F/I/U     | Dependent Status                          |  |
|  |                                      |                                   | OM OF              | O Disabled O Student - College/University |  |
|  |                                      |                                   | OM OF              | O Disabled                                |  |
|  |                                      |                                   | OH OF              | O Student - College/University O Disabled |  |
| If digible the Dependent Life banefit will be seen   | idad gutamatically if the devel      | dont information is provided with | OI OU              | O Student - College/University            |  |
| If eligible, the Dependent Life benefit will be prov   |                                      | uent information is provided wit  | min this section o | ir Section 3 - Deneficiary.               |  |
| OTHER COVERAGE (CO-ORDINATION OF BI<br>Do you or any of your dependents have coverage<br>Name of the Other Insurer:  | ge under any other Plan?             | -                                 |                    | <b>ng:</b><br> DD/MM/YYYY):               |  |
| Policy Number  |                                      | ID Number                         |                    | . 4                                       |  |



Trustee

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| 7 OPTIONAL COVERAGE (PL   | FASE CONI  |   | DUCABLE  | PENEFITE WITH  | LVOUR  | CDOUD  | DMI  | NICTRA   | TOD   |   |
|---|--|---|--|--|--|--|--|--|---|---|
| 3 OPTIONAL COVERAGE (PL   |  |   |  |  |  |  |  |  | (IOR)   |   |
| If applying for Optional Coverage, the  |  |   |  |  |  | •  |  |  | ) N-  |   |
| Do you use tobacco products?  |  |   |  | your spouse use  |  |  |  |  | ) No  |   |
| Answer "No" if you have not used any  |  | •   | -  | •  | •  | -  | -  |  | •   | nonths.   |
| •   | Employee E   | . ,   |  |  |  | pouse  | Spo  | Jse Amo  | unt \$  |   |
| Optional Dependent Child Life:  |  |   |  |  |  |  | _  |  |   |   |
| -   |  |   | Amount \$ _  | 25 1 0   |  | pouse  | Spo  |  |   |   |
| Optional Accidental Death & Dismer  | nberment:  | O Employ  | yee Only   | O Employee &   | Family   |  |  | Amo  | unt \$  |   |
| 4 WAIVER OF COVERAGE  |  |   |  |  |  |  |  |  |   |   |
| All benefits under your group insurand dental benefits if you have similar cov  |  |   |  | to you based on  | the group  | contract. I  | Howe   | ver, you r   | may waive t   | :he health and  |
| O I have been given the opportunity later date without the mutual cons that time.   |  |   |  |  |  |  |  |  |   |   |
| O I understand that should I lose spo<br>required to submit medical evidence  | •  |   |  | •  | . ,  |  | •  | • .  | •   | ,   |
| I do not want to participate in the foll  | owing covera   | ge: OF  | Health O   | Dental O Bot   | h Health   | and Dental   |  |  |   |   |
| For Québec Residents: Participation please complete your spouse's covera  |  | •   | plan can only  | be declined due  | to spouse  | e coverage.  | If de  | clining th   | ie Health c   | overage,  |
| 5 BENEFICIARY DESIGNATIO  |  |   | FORMATIO   | N  |  |  |  |  |   |   |
| Any beneficiary(ies) designated below A revocable designation can be che An irrevocable designation require change the allocation amount (%). consent.  If the beneficiary designation is not sp. married or civil union spouse designate Benefits are paid to the designated be paid to the estate of the deceased em insured's death, Medavie Blue Cross w as administrator/trustee of the procee your will. You may also want to consult  Primary Beneficiary(ies)  First Name | anged at any to<br>s the written of<br>The beneficial<br>ecified, it will be<br>ed as the beneficiary(ies) by<br>ployee. For the<br>will pay the pro-<br>ds. If you wish | time by co<br>consent of<br>ary must be<br>be conside<br>eficiary is p<br>below. If a<br>e Province<br>oceeds to p<br>to have a | the named irrect of the age of th | submitting a new evocable beneficing from the end of th | iary in ord<br>he province<br>he excepti<br>ss specifie<br>appointed<br>ary of a lif<br>an, if appli<br>e child's po | er to remove ital jurisdict ion of Quebed as revocated and the before insurance cable), and roceeds, you blanning steems | ion of<br>nec. <i>In</i><br>uble.<br>elow f<br>e polic<br>not to<br>u show | the provied the province of th | ince of Que<br>left blank,<br>nor at the ti<br>else who m<br>the proper | e the written  ebec, a legally  benefits are me of the hight be named provisions in |
|   |  |   |  |  |  |  |  |  |   |   |
|   |  |   |  |  |  |  |  |  |   |   |
| Contingent Beneficiary(ies): The ind  | ividual(s) desi  | gnated by   | the Employe  | e to receive bene  | fits in the  | event the p  | orima  | ry benefi  | ciary is dec  | eased.  |
| First N   | ame  |   |  | Last Name  |  | Date of Bi<br>(DD/MM/YY  |  | Percent<br>(Must total   |   | Relationship  |
| Contingent<br>Beneficiary(ies)  |  |   |  |  |  |  |  |  |   |   |
| Contingent<br>Beneficiary(ies)  |  |   |  |  |  |  |  |  |   |   |
| <b>Trustee:</b> A person given control or pow<br>For designated beneficiaries considere<br>jurisdiction of residence.   | ed a minor, a Tr   |   |  | ımount due for an  | y benefici   |  | red a  | minor un   | der the pro   | vincial   |
| First Na  | me   |   |  | Last Name  | •  |  |  | te of Birth<br>/MM/YYYY  |   | lationship  |

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: O 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.                                       | " 184" 1:00502"0 101: 70"5555                         |
| Name(s) of Account Holder (as it appears on the cheque):  | Branch/ Fincancial Account Transit Institution Number |
| Name of Financial Institution:  | Number Number   |
| 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 o | r 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 (Blue Cross Life), 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 Medavie Blue Cross and/or Blue Cross Life'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 Medavie Blue Cross and/or Blue Cross Life 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 Medavie Blue Cross and/or Blue Cross Life 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 and/or Blue Cross Life, visit medavie by car or call 1-800-667-4511.

| information regarding privacy policies at medavic Bioc cross and/or Bioc cross Ene, visit incade  | Viebeled of edit 1 000 007 4511.                    |
|---|---|
|   |   |
|   |   |
| 8 AUTHORIZATION   |   |
| I certify that the information above is accurate and authorize payroll deductions, if required. I appersonal information as described in the Privacy Consent section above. | uthorize Blue Cross to collect, use and disclose my |
| 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 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.



