MEDAVIE BLUE CROSS
SENIORS' HEALTH PROGRAM

644 MAIN ST
PO BOX 220
MONCTON NB
E1C 8L3

APPLICATION FOR SPOUSE

Toll-Free Number: 1-844-209-7599 **Fax: 1-855-551-9984**

PLEASE COMPLETE THE FOLLOWING TO APPLY FOR BENEFITS

Name: _____

Address: _____

_____ Postal Code: _____

E-Mail: _____ Telephone: _____

Date of Birth (DD/MM/YY): _____ Medicare No.: _____

Language preference for correspondence: ○ English ○ French

Sex: ○ Male ○ Female ○ Intersex ○ Undisclosed

Sex: Male/Female/Intersex/Undisclosed – *Why do we ask?* Some health conditions are more likely to occur based on sex. As a result, sex is used to assess your coverage. We recognize that your sex may differ from your gender identity.

BENEFIT SELECTION - Please refer to the Medavie Blue Cross Seniors' Health Program booklet for a complete description of the benefits. The amounts shown below are monthly rates.

Waiting periods apply for Hospital and Dental benefits. There may also be a one year waiting period on some health benefits if you do not apply within 60 days of your 65th birthday.

Please check all benefits you wish to include in your plan.

HEALTH COVERAGE

The following options do not include coverage for prescription drugs.

- ☐ $20.00 Basic Health Benefits
- ☐ $30.00 Enhanced Health Benefits (includes the benefits under Basic)
- ☐ $31.50 Hospital Reimbursement Plan

The following options are available for Individual Dental (Billed separately)*

- ☐ $54.63 Spouse aged 55 to 64

*If you are age 54 or younger, please contact us at 1-844 -209-7599 for rates.

INFORMATION ON SPOUSE AGED 65 OR OVER

Name of Spouse: _____ Date of Birth (DD/MM/YYYY): _____

Medicare No.: _____

BILLING SELECTION - Please see reverse of this page for Billing Information.

Have you recently been covered for other health benefits, such as Vision or Physiotherapy? ○ Yes ○ No

Have you been covered for dental benefits in the last three months? ○ Yes ○ No

If Yes, when will these benefits terminate? (DD/MM/YYYY) _____

Your coverage becomes effective on the first day of the month of your spouse's 65th birthday unless you are a late applicant or request a different effective date.

Requested Effective Date of Policy: Please begin my coverage on the 1st day of (Month/Year) _____

I hereby apply for the benefit indicated above.

Signature _____ Date (DD/MM/YYYY) _____

BILLING SELECTION

☐ **Monthly Pre-authorized Debit (PAD)** (Please complete the Pre-authorized Debit (PAD) plan agreement below, sign, date and attach void cheque).

I authorize Medavie Blue Cross, and the financial institution designated (or any other financial institution I may authorize at any time), to begin deductions as per my instructions for recurring payments and/or one-time payments, from time to time, for payment of insurance premiums. Regular monthly payments will be debited from my specified account on the first business day of every month. ***Medavie Blue Cross will not provide monthly pre-notification but will provide 30-days notice if the deduction is subject to change.*** Medavie Blue Cross will obtain my authorization for any other one-time or sporadic debits. Medavie Blue Cross requires written notification of any changes to banking information.

This authority is to remain in effect until Medavie Blue Cross has received written notification from me of its change or termination. This notification must be received at least 30 business days before the next debit is scheduled. This notification must be sent to the Seniors' Health Program at Medavie Blue Cross. I may obtain a sample cancellation form or more information on my right to cancel a PAD Agreement at my financial institution or by visiting www.payments.ca.

I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. To obtain a form for a Reimbursement Claim, or for more information on my recourse rights, I may contact my financial institution or visit www.payments.ca.

Authorized Signature: _____ **DATE (DD/MM/YYYY):** _____

Type of Service: ○ Personal ○ Business

Please attach a void cheque. (Credit card payments are not accepted.)
(PLEASE PRINT)

Financial Institution (FI): _____

Address: _____

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

FI Transit Number: |_|_|_|_|_| |_|_|_| (transit-5 digits; FI-3 digits) FI Account Number: |_|_|_|_|_|_|_|_|_|_|_|_|

Would you like your claim reimbursements automatically deposited in the same account? ○ Yes ○ No

If someone other than the policy owner will be paying the premiums, please have them sign, date and complete their financial information above and complete their personal information below:

Name: _____

Address: _____

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

Phone Number: (Bus.) _____ (Res.) _____

FOR OFFICE USE ONLY

I hereby certify that, as an agent for Medavie Blue Cross, I have informed the applicant of the importance of making full and accurate disclosure of the matters covered in this application and that any misrepresentations or omissions may give Medavie Blue Cross the right to cancel the contract of insurance and refuse coverage under the policy. I have disclosed the company or companies I represent and any conflicts of interest they may have with respect to this transaction and that I may receive a salary, commissions or other forms of compensation for the sale of insurance company products.

Agent's Name: _____ Agent's Number: _____

Telephone Number: _____ Fax Number: _____

E-mail Address: _____

Agent's Signature: _____

TEN DAY RIGHT TO EXAMINE POLICY

You have 10 days from the receipt of the policy to examine and return it for a full refund of monies paid, if you are not entirely satisfied. Accidental death benefits will be underwritten by Blue Cross Life Insurance Company of Canada. All other benefits will be underwritten by Medavie Inc., operating under the business name Medavie Blue Cross.