MEDAVIE BLUE CROSS™

GROUP BENEFITS ENROLMENT FORM INCLUDING OPTIONAL BENEFITS DEFINED

The Group Benefits Enrolment Form Including Optional Benefits is used by Group Administrators to advise Medavie BlueCross of the addition of a new employee to their group benefit plan. It should be completed and forwarded to Medavie Blue Cross as soon as the addition is known. This will keep records up-to-date so billings, claims and inquiries can be handled efficiently.

The below information is provided as standard guidelines. Please refer to your Contract/ Booklet for specific terms and conditions of your policy.

SECTION 1 – TO BE COMPLETED BY THE EMPLOYER

This section is reserved for the employer as it requires specific information related to the employee's employment.

SECTION 2 – EMPLOYEE AND FAMILY INFORMATION

Please ensure that the information in this section is completed correctly, as this information will be displayed on the identification card/identification card carrier.

The family information includes the employee's spouse and all dependent children. If a dependent child exceeds the maximum dependent age per your Group Benefits Contract/ Booklet and is attending an accredited educational institution as a full time student, student status is to be selected to indicate College/University student.

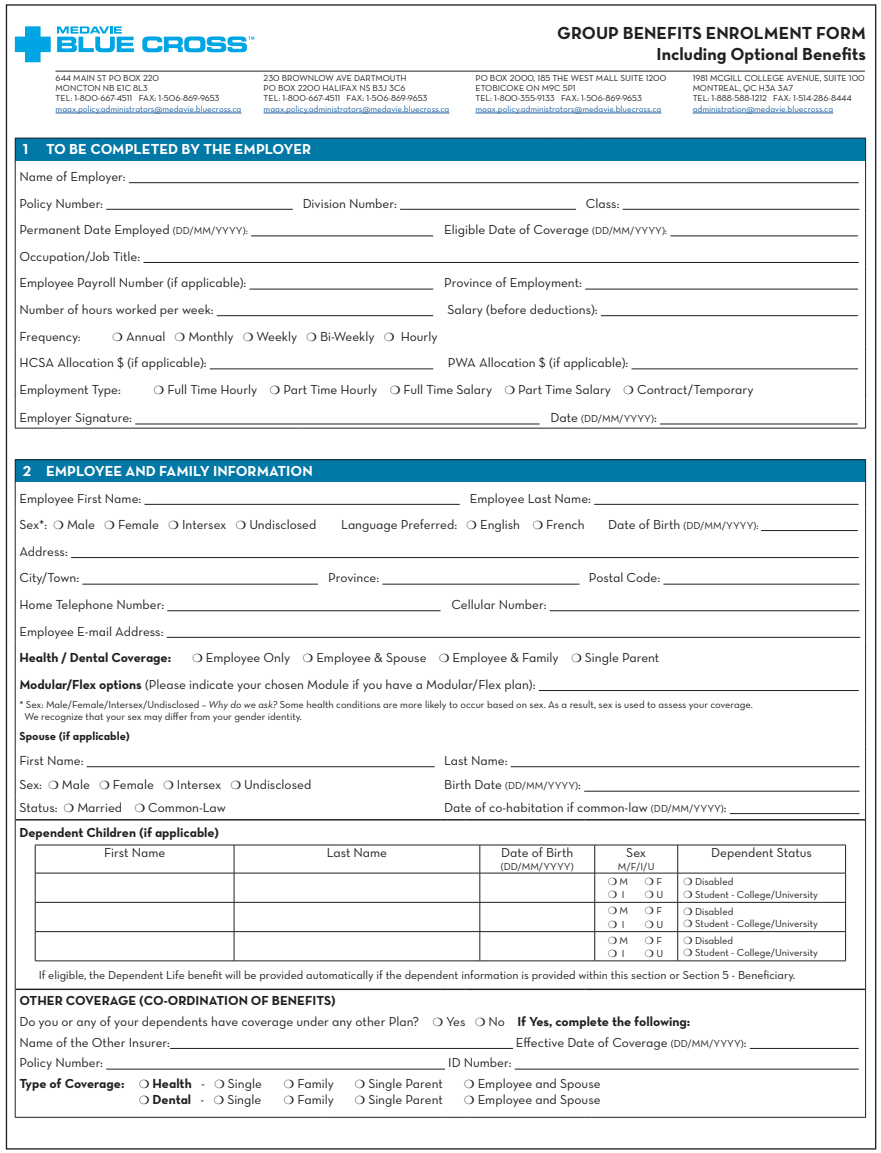
Selecting disabled indicates that the dependent has a disability, and a 'Special Dependent Questionnaire' is to be completed in addition to the 'Group Benefits Enrolment' form. The 'Special Dependent Questionnaire' can be requested or printed from our Corporate Web Site (www.medaviebc.ca).

If the employee is in a common-law relationship, indicate the date of co-habitation. A common-law spouse is considered a person with whom the employee has been residing for a minimum period at the time of enrolment and is publicly represented as a spouse. The standard co-habitation period is 12 months.

OTHER COVERAGE (COORDINATION OF BENEFITS)

If the employee or their dependents have other Health/Dental coverage, provide the details of the plan and the type of coverage in order to coordinate both coverages.

Claims for spouse with coverage must be submitted to their plan first. Claims for insured children must be submitted to the plan of the employee or spouse with the earlier date of birth in the year.



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Including Optional Benefits

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

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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): _____ PWA 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: _____

Sex*: ❍ Male ❍ Female ❍ Intersex ❍ Undisclosed Language Preferred: ❍ English ❍ French Date of Birth (DD/MM/YYYY): _____

Address: _____

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

Home Telephone Number: _____ Cellular Number: _____

Employee E-mail Address: _____

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

Modular/Flex options (Please indicate your chosen Module if you have a Modular/Flex plan): _____

* 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.

Spouse (if applicable)

First Name: _____ Last Name: _____

Sex: ❍ Male ❍ Female ❍ Intersex ❍ Undisclosed 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)	Sex M/F/I/U	Dependent Status
			❍ M ❍ F ❍ I ❍ U	❍ Disabled ❍ Student - College/University
			❍ M ❍ F ❍ I ❍ U	❍ Disabled ❍ Student - College/University
			❍ M ❍ F ❍ I ❍ U	❍ 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

SECTION 3 - OPTIONAL BENEFITS

The coverage selection is based on the benefits made available to you per your Group Benefits Contract/Booklet. If any of the benefits are being selected, a "Statement of Health" form must be completed in addition to the "Group Benefits Enrolment" form. The "Statement of Health" form can be sent to you on request or printed from the medaviebc.ca website.

SECTION 4 - WAIVER OF COVERAGE

If the employee chooses to waive or decline their health and/or dental coverage due to having alternate coverage, such as their spouse's insurance plan, this section must be completed.

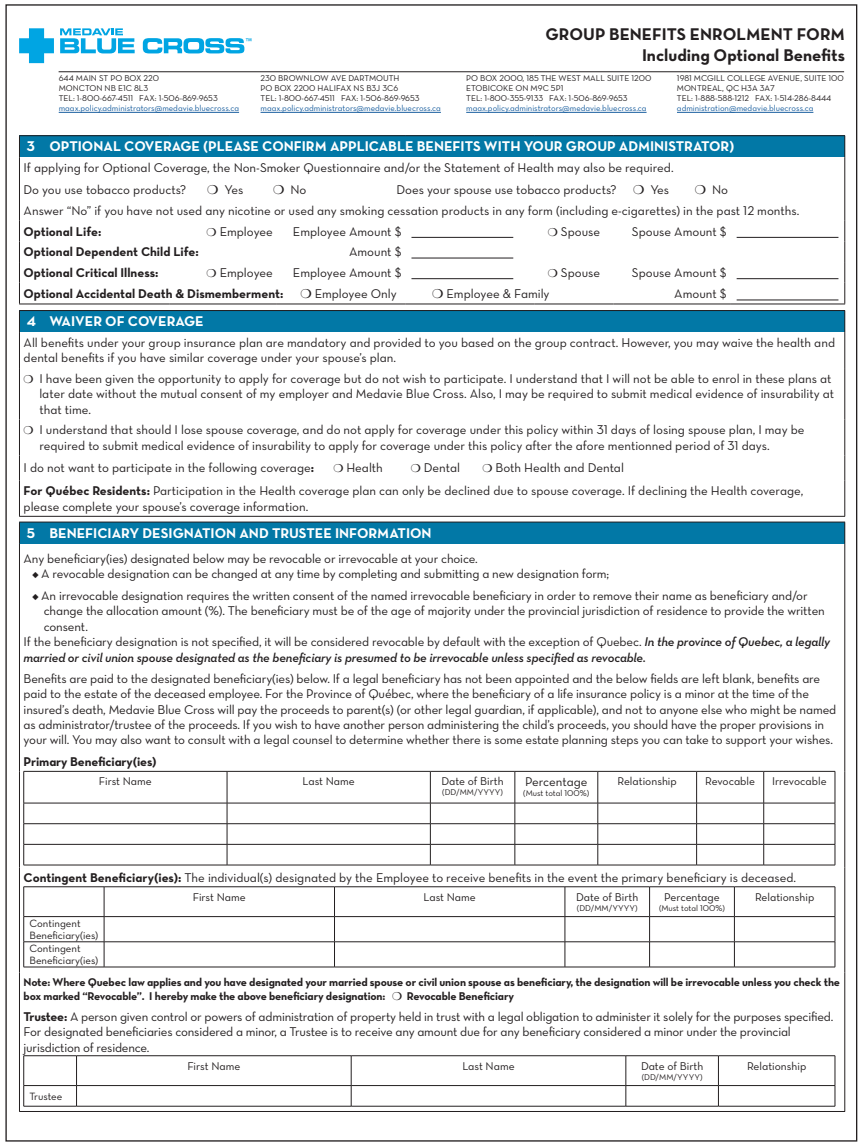
SECTION 5 - EMPLOYEE AND FAMILY INFORMATION

The beneficiary designation applies to Basic Life, Optional Life Coverage, Accidental Death and Dismemberment and Optional Accidental Death and Dismemberment coverages.

Dependent Life, Optional Spouse Life and Optional Dependent Child Life benefits automatically defer to the employee as the designated beneficiary unless otherwise stated.

If a legal beneficiary has not been appointed and the beneficiary fields are left blank, benefits are paid to the estate of the deceased employee. Therefore, it is important to complete all fields accurately.

The sum of each percentage allocated to designated beneficiaries must total of 100%. If a designated beneficiary is deemed irrevocable, the employee may not change their beneficiary at any time. They require the said beneficiary's written consent.



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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 Does your spouse 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 $ _____

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'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 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 spouse coverage, and do not apply for coverage under this policy within 31 days of losing spouse 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 spouse coverage. If declining the Health coverage, please complete your spouse's coverage information.

5 BENEFICIARY DESIGNATION AND TRUSTEE INFORMATION

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 Quebec. ***In the province of Quebec, a legally married or civil union spouse designated as the beneficiary is presumed to be irrevocable unless specified as revocable.***

Benefits are paid to the designated beneficiary(ies) below. If a legal beneficiary has not been appointed and the below fields are left blank, benefits are paid to the estate of the deceased employee. For the Province of Québec, where the beneficiary of a life insurance policy is a minor at the time of the insured's death, Medavie Blue Cross will pay the proceeds to parent(s) (or other legal guardian, if applicable), and not to anyone else who might be named as administrator/trustee of the proceeds. If you wish to have another person administering the child's proceeds, you should have the proper provisions in your will. You may also want to consult with a legal counsel to determine whether there is some estate planning steps you can take to support your wishes.

Primary Beneficiary(ies)

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

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)					

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

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				

SECTION 6 – DIRECT DEPOSIT

Direct Deposit enables your reimbursement to be automatically deposited into the bank account of your choice once your claim has been submitted and approved. The banking information can also be updated by using our Member Service Site or our Mobile App.

Direct Deposit can be cancelled at any time by providing a 30 days written notice to Medavie Blue Cross.

SECTION 7 – PRIVACY CONSENT

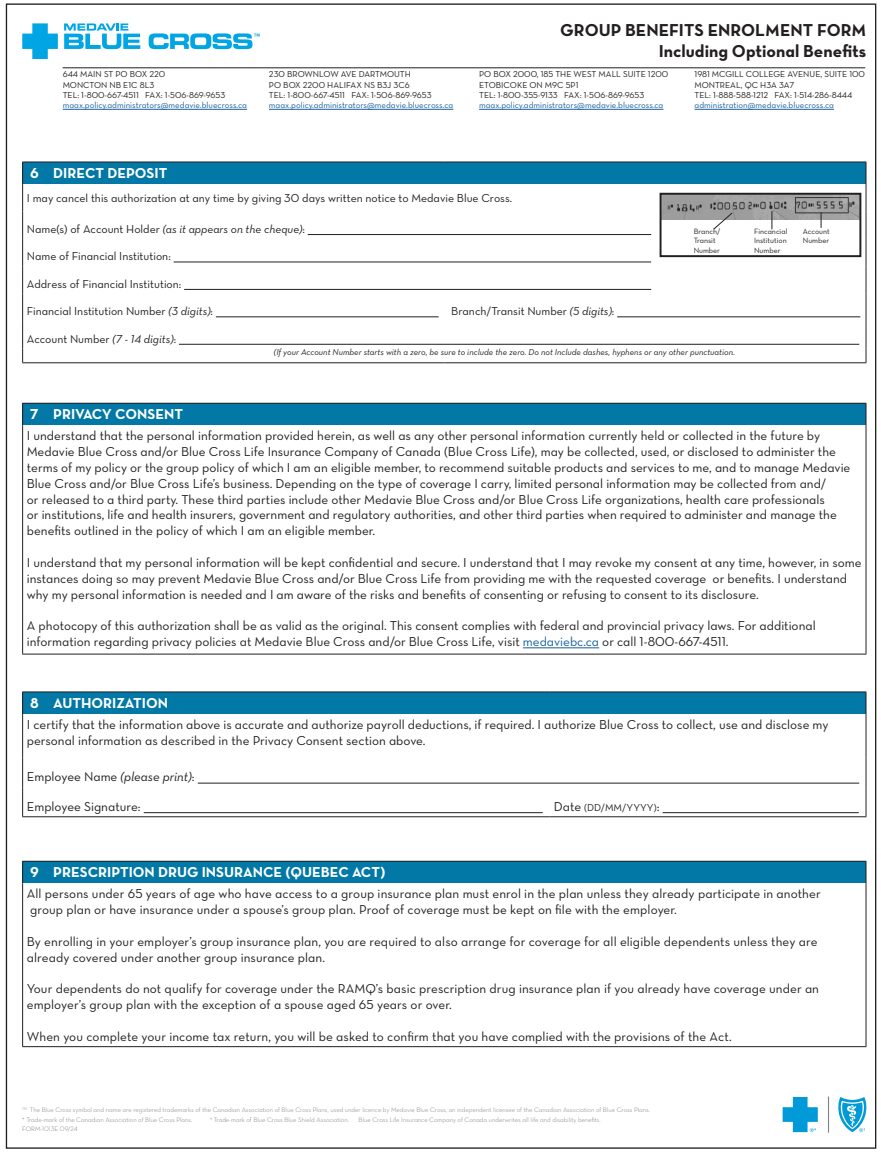
The Privacy Consent agreement is obtained at time of enrolment and also at time of claim through the use of detailed consent statements on our standard forms. An individual may revoke their consent at any time, however, in certain situations this could result in our inability to provide coverage.

SECTION 8 – AUTHORIZATION

In order for the enrolment to be processed by Medavie Blue Cross, signatures from the employee as well as the employer along with the date must be completed within the Authorization section.

SECTION 9 – PRESCRIPTION DRUG INSURANCE (QUEBEC ACT)

If you are a resident of Québec, please ensure to review the prescription drug act guidelines.



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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.

Branch/ Transit Number | Financial Institution Number | Account Number

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 (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 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 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.