GROUP BENEFITS ENROLMENT FORM DEFINED

The Group Benefits Enrolment form is used by Group Administrators to advise Medavie Blue Cross 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.

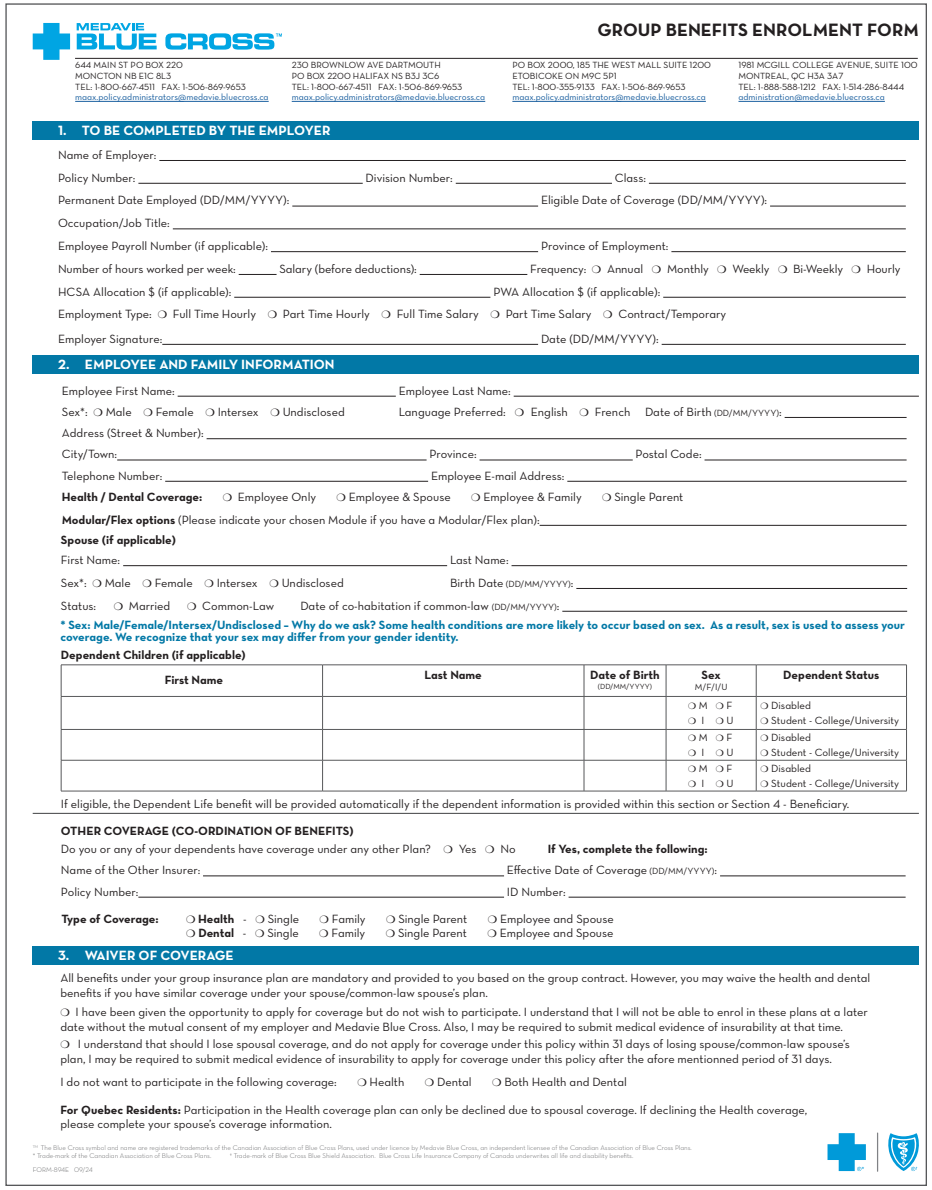
OTHER COVERAGE (COORDINATION OF BENEFITS)

If the employee or his/her 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 his/her 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.

SECTION 3 – 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.



MEDAVIE BLUE CROSS

GROUP BENEFITS ENROLMENT FORM

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): _____ 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 (Street & Number): _____

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

Telephone 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): _____

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): _____

*** 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.**

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 4 - 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

3. 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 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 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 spouse's 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 Quebec 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.

FORM-8946E 09/24

SECTION 4 – BENEFICIARY

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

SECTION 5 – 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 6– PRIVACY CONSENT

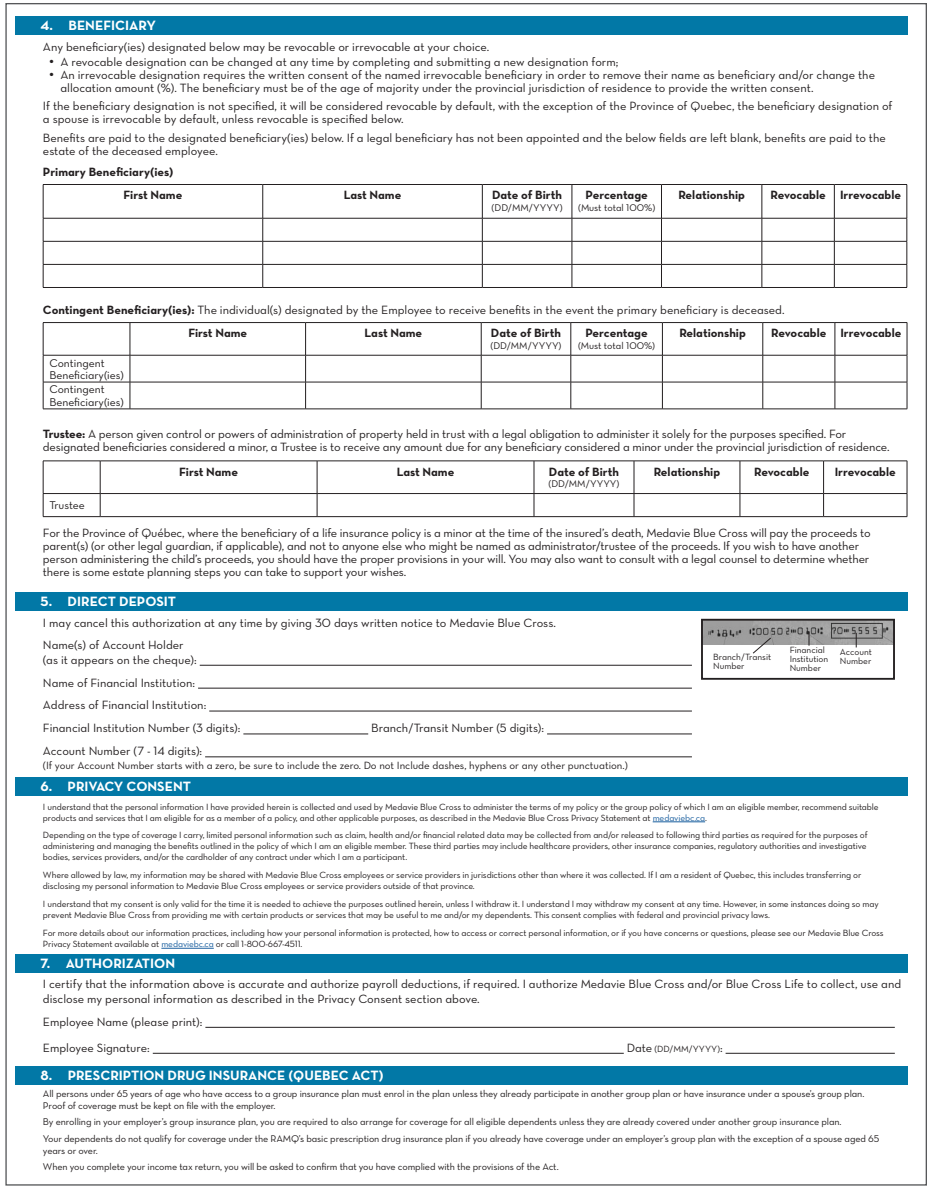
The Privacy Consent agreement is obtained at time of enrolment and also at time of claim through the use of detailed consent statements on our standard forms. An individual may revoke their consent at any time, however, in certain situations this could result in our inability to provide coverage.

SECTION 7 – 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 8 – PRESCRIPTION DRUG INSURANCE (QUEBEC ACT)

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



4. 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 beneficiary 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	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	Revocable	Irrevocable
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	Revocable	Irrevocable
Trustee						

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.

5. 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.)

6. PRIVACY CONSENT

I understand that the personal information I have provided herein is collected and used by Medavie Blue Cross to administer the terms of my policy or the group policy of which I am an eligible member, recommend suitable products and services that I am eligible for as a member of a policy, and other applicable purposes, as described in the Medavie Blue Cross Privacy Statement at medavieblue.ca.

Depending on the type of coverage I carry, limited personal information such as claim, health and/or financial related data may be collected from and/or released to following third parties as required for the purposes of administering and managing the benefits outlined in the policy of which I am an eligible member. These third parties may include healthcare providers, other insurance companies, regulatory authorities and investigative bodies, services providers, and/or the cardholder of any contract under which I am a participant.

Where allowed by law, my information may be shared with Medavie Blue Cross employees or service providers in jurisdictions other than where it was collected. If I am a resident of Quebec, this includes transferring or disclosing my personal information to Medavie Blue Cross employees or service providers outside of that province.

I understand that my consent is only valid for the time it is needed to achieve the purposes outlined herein, unless I withdraw it. I understand I may withdraw my consent at any time. However, in some instances doing so may prevent Medavie Blue Cross from providing me with certain products or services that may be useful to me and/or my dependents. This consent complies with federal and provincial privacy laws.

For more details about our information practices, including how your personal information is protected, how to access or correct personal information, or if you have concerns or questions, please see our Medavie Blue Cross Privacy Statement available at medavieblue.ca or call 1-800-667-4511.

7. AUTHORIZATION

I certify that the information above is accurate and authorize payroll deductions, if required. I authorize Medavie Blue Cross and/or Blue Cross Life 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): _____

8. 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.