

Toll-Free Number: 1-844-209-7599

Fax: 1-855-551-9984

PLEASE COMPLETE THE FOLLOWING TO APPLY FOR BENEFITS

Name: _____

Address: _____

_____ Postal Code: _____

Telephone: _____ Date of Birth: _____ DD/MM/YYYY

Medicare No.: _____

Language preference for correspondence: English French Sex: Male Female

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.

- \$10.50 Basic Health Benefits
- \$21.00 Enhanced Health Benefits (includes the benefits under Basic)
- \$31.50 Hospital Reimbursement Plan

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

- \$40.87 **Male Spouse** aged 55 to 64
- \$39.37 **Female 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/YY

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

