

## Application for Group Insurance

This package contains the following forms:

- 1) Application for Group Insurance Confirmation Agreement
- 2) Pre-authorized Debit (PAD) Agreement
- 3) Internet Services Access Form

Please complete this form in its entirety.

**1 POLICYHOLDER INFORMATION**

Legal Name of Policyholder:

Policyholder Contact Info:

Business Mailing Address		
City/Town	Province	Postal Code
Business Telephone	Business Fax	Business Email Address
Business Website Address		

Company Executive:

Name	Telephone	Email Address
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Group Administrator:

Name	Telephone	Email Address
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General Nature of Business:

**2 DETAILS OF THE APPLICATION**

Application is hereby made to Medavie Inc., and/or Blue Cross Life Insurance Company of Canada for group insurance in accordance with the specifications relating to the application for group coverage. Health and/or dental benefits are underwritten by Medavie Inc.; all other benefits are underwritten by Blue Cross Life Insurance Company of Canada.

This insurance will become effective at 12:01am local time on: \_\_\_\_\_ provided that:  
Date (yyyy-mmm-dd)

- a) this application has been approved by Medavie Blue Cross;
- b) a deposit of \$ \_\_\_\_\_, equal to approximately one month of premium, has been paid; and
- c) in the case of contributory plans, at least \_\_\_\_\_% of the eligible employees have applied for coverage on the appropriate forms, or in the case of non-contributory plans, 100% of the eligible employees have applied for coverage on the appropriate forms.

The first renewal date will be 12:01am local time on: \_\_\_\_\_ .  
Date (yyyy-mmm-dd)

**3 ADDITIONAL QUESTIONS**

- 1. Are there any plan members of the group who are covered through a union?  Yes  No
- 2. Are the plan members covered by a workers' compensation board/commission?  Yes  No
- 3. What benefits have been sold and what are the employer/employee contribution percentages (if applicable)?

Complete the Following Table:

	Check Box if Benefit Sold	Employer	Employee		Check Box if Benefit Sold	Employer	Employee
Life	<input type="checkbox"/>	%	%	Optional Life	<input type="checkbox"/>	%	%
AD&D	<input type="checkbox"/>	%	%	Extended Health Care	<input type="checkbox"/>	%	%
Dependent Life	<input type="checkbox"/>	%	%	Dental	<input type="checkbox"/>	%	%
STD (WI)	<input type="checkbox"/>	%	%	Second Opinion	<input type="checkbox"/>	%	%
LTD	<input type="checkbox"/>	%	%	inConfidence EFAP	<input type="checkbox"/>	%	%
Critical Conditions	<input type="checkbox"/>	%	%	HSA	<input type="checkbox"/>	N/A	N/A

- 4. What are the minimum number of hours for plan eligibility?  20 hours  24 hours  Other: \_\_\_\_\_
- 5. Is enrolment in this plan mandatory (i.e. a condition of employment)?  Yes  No
- 6. Is there a waiting period for new employees?  Yes  No If yes, waiting period is: \_\_\_\_\_
- 7. Is the waiting period waived for existing employees?  Yes  No
- 8. What is the total number of active employees? \_\_\_\_\_

**3 ADDITIONAL QUESTIONS CON'T**

9. Are all employees actively at work?  Yes  No If No, provide details below (attach sheet if necessary)

Name of Employee	Last Day Worked (yyyy-mmm-dd)	Comments
A. _____	_____	_____
B. _____	_____	_____
C. _____	_____	_____

10. Will this policy replace existing coverage?  Yes  No

If yes, will the previous carrier cover all employees not actively at work on the date of this application for any disability benefits?  Yes  No

11. Are there any employees working outside of the policyholder's home province (specified in Section A)?  Yes  No

If Yes, specify:  BC  SK  ON  NB  NS  
 AB  MB  QC  PE  NL  Other: \_\_\_\_\_

12. In what language should the contract be issued?  English  French

13. How should the policy(ies) be delivered?  Electronically  By mail

14. How should the booklets be delivered?  Electronically  By mail

15. HSA Plan details (if applicable)

Applicable to which classes: \_\_\_\_\_ Opt outs of Health and Dental eligible?  Yes  No

Effective Date: \_\_\_\_\_  Policy Year  Calendar Year Benefit Waiting Period: \_\_\_\_\_

Credit Carry Forward  Claim Carry Forward  No Carry Forward

Yearly Allocation amount:  Varied Amounts  Flat Amount \$ \_\_\_\_\_ Prorated to effective date?  Yes  No

Reimbursement on Request  Automatic If Automatic, allow members to opt out of automatic features?  Yes  No

Grace period: Active Employees \_\_\_\_\_ days Terminated Employees \_\_\_\_\_ days

Exclude CRA Dependents  Exclude Line of Benefit (LOB)  Exclude Specific Benefit(s)

HSA Administrative Fee: \_\_\_\_\_ Separate HSA Bill?  Yes  No Will History be loaded?  Yes  No

**4 SIGNATURE OF AUTHORIZED OFFICER**

It is understood and agreed that acceptance of any policies issued as a result of the application for group coverage shall constitute approval of the provisions of the policies.

Signed for the Policyholder this \_\_\_\_\_ at \_\_\_\_\_  
Date (yyyy-mmm-dd) City/Town

Signature of Authorized Officer: \_\_\_\_\_

Name of Authorized Officer: \_\_\_\_\_

Title of Authorized Officer: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_

**IMPORTANT:** If you have a group insurance policy insuring any benefits for which you are now applying, do not cancel the other insurance until this application has been approved by Medavie Blue Cross.

**5 FOR BROKER/AGENT/CONSULTANT USE ONLY (IF APPLICABLE)**

I hereby certify that, as a broker/agent/consultant for Medavie Blue Cross, I have disclosed the company or companies I represent and any conflicts of interest I 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.

Broker/Agent/Consultant Name:	_____	Broker/Agent/Consultant #:	_____
Broker/Agent/Consultant Signature:	_____		

Please complete this form in its entirety.

**1 POLICYHOLDER INFORMATION**

Legal Name of Policyholder:

Policyholder Contact Info:

Business Mailing Address		
City/Town	Province	Postal Code
Business Telephone	Business Fax	Business Email Address
Business Website Address		

Medavie Blue Cross  
Policy Information:  
(attach sheet if necessary)

Policy Number(s)	Section Number(s)
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**2 ACCOUNT INFORMATION (you may skip this section if a void cheque or bank issued and stamped PAD form is attached)**

Name of Financial Institution:

Contact Info:

Business Mailing Address		
City/Town	Province	Postal Code

Account Info:

Transit (Branch) #	FI (Bank) #	Account #

**3 SIGNATURE OF AUTHORIZED OFFICER**

I/We authorize Medavie Blue Cross, and the financial institution designated (or any other financial institution I/we may authorize at any time) to begin deductions as per my/our instructions for recurring payments and/or one-time payments from time to time, for payment of insurance premiums. Regular monthly payments for the full amount of services delivered will be debited to my/our specified account on the first business day of every month. Medavie Blue Cross will not provide pre-notification but will provide a monthly premium statement indicating the amount of each regular debit. Medavie Blue Cross will obtain my/our 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/us of its change or termination. This notification must be received at least ten (10) business days before the next debit is scheduled. This notification must be sent to the Billing Department of Medavie Blue Cross. I/We may obtain a sample cancellation form, or more information on my/our right to cancel a PAD Agreement at my/our financial institution or by visiting [www.cdnpay.ca](http://www.cdnpay.ca).

I/We have certain recourse rights if any debit does not comply with this agreement. For example, I/we 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/our recourse rights, I/we may contact my/our financial institution or visit [www.cdnpay.ca](http://www.cdnpay.ca).

Signature of Account Holder(s): \_\_\_\_\_

Name of Account Holder(s): \_\_\_\_\_

Date (yyyy-mmm-dd): \_\_\_\_\_

**Please advise Medavie Blue Cross of any future changes in banking information related to this PAD agreement.**



**1**

Company Name: \_\_\_\_\_

Are you a:  Group Administrator  Agent/Broker/Advisor Agent Number: \_\_\_\_\_

Name: \_\_\_\_\_

**2 NEW USERS**

Name: \_\_\_\_\_

Work E-mail: \_\_\_\_\_ Work Telephone Number: \_\_\_\_\_

Existing Blue Cross User Name (if applicable): \_\_\_\_\_ Language Preference:  English  French

New User

For multiple new users, please complete Appendix A.

Policy Numbers	Division(s) "All" or Specify	Classes (if applicable)	View Only Information pertaining to employee	View and Update Employee Information and enrolled employees	View E-bills	View Contract and Booklets	Reporting View Statistical Reports (if applicable)	Cardholder Website - Would you like to receive an e-mail informing you of the changes made online by your employees? - Check for Yes
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional Policies / Divisions / Class or Comments: \_\_\_\_\_

**3 AUTHORIZATION**

I hereby authorize the new users noted to have access to the policies/divisions and functions outlined above. I am duly authorized to act on the behalf of the company in making this request.

Name: \_\_\_\_\_

Title: \_\_\_\_\_ Company: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**4 PLEASE FORWARD THE COMPLETED INTERNET SERVICES ACCESS FORM TO THE APPROPRIATE REGION BELOW:**

**ATLANTIC, ONTARIO AND OTHER REGIONS**  
 Telephone: 1-888-564-2155 Fax: 506-867-4651  
 E-mail: webadmin.inquiry@medavie.bluecross.ca

**QUEBEC REGION**  
 Telephone: 1-800-456-6595 Fax: 514-286-8444  
 E-mail: administration@medavie.bluecross.ca

**Once the access form is processed, the user will receive two emails containing the following:**

**Email 1: Username**

**Email 2: Temporary Password**



Name (User 2): \_\_\_\_\_  
 Work E-mail: \_\_\_\_\_ Work Telephone Number: \_\_\_\_\_  
 Existing Blue Cross User Name (if applicable): \_\_\_\_\_ Language Preference:  English  French

Policy Number	Division(s) "All" or Specify	Classes (if applicable)	View Only Information pertaining to employee	View and Update Employee Information and enrolled employees	View E-bills	View Contract and Booklets	Reporting View Statistical Reports (if applicable)	Cardholder Website - Would you like to receive an e-mail informing you of the changes made online by your employees? - Check for Yes
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Name (User 3): \_\_\_\_\_  
 Work E-mail: \_\_\_\_\_ Work Telephone Number: \_\_\_\_\_  
 Existing Blue Cross User Name (if applicable): \_\_\_\_\_ Language Preference:  English  French

Policy Number	Division(s) "All" or Specify	Classes (if applicable)	View Only Information pertaining to employee	View and Update Employee Information and enrolled employees	View E-bills	View Contract and Booklets	Reporting View Statistical Reports (if applicable)	Cardholder Website - Would you like to receive an e-mail informing you of the changes made online by your employees? - Check for Yes
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Name (User 4): \_\_\_\_\_  
 Work E-mail: \_\_\_\_\_ Work Telephone Number: \_\_\_\_\_  
 Existing Blue Cross User Name (if applicable): \_\_\_\_\_ Language Preference:  English  French

Policy Number	Division(s) "All" or Specify	Classes (if applicable)	View Only Information pertaining to employee	View and Update Employee Information and enrolled employees	View E-bills	View Contract and Booklets	Reporting View Statistical Reports (if applicable)	Cardholder Website - Would you like to receive an e-mail informing you of the changes made online by your employees? - Check for Yes
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Name (User 5): \_\_\_\_\_  
 Work E-mail: \_\_\_\_\_ Work Telephone Number: \_\_\_\_\_  
 Existing Blue Cross User Name (if applicable): \_\_\_\_\_ Language Preference:  English  French

Policy Number	Division(s) "All" or Specify	Classes (if applicable)	View Only Information pertaining to employee	View and Update Employee Information and enrolled employees	View E-bills	View Contract and Booklets	Reporting View Statistical Reports (if applicable)	Cardholder Website - Would you like to receive an e-mail informing you of the changes made online by your employees? - Check for Yes
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Name (User 6): \_\_\_\_\_  
 Work E-mail: \_\_\_\_\_ Work Telephone Number: \_\_\_\_\_  
 Existing Blue Cross User Name (if applicable): \_\_\_\_\_ Language Preference:  English  French

Policy Number	Division(s) "All" or Specify	Classes (if applicable)	View Only Information pertaining to employee	View and Update Employee Information and enrolled employees	View E-bills	View Contract and Booklets	Reporting View Statistical Reports (if applicable)	Cardholder Website - Would you like to receive an e-mail informing you of the changes made online by your employees? - Check for Yes
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

