MEDAVIE BLUE CROSS™

medaviebc.ca

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

FORM-749E 08/18

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MEDAVIE BLUE CROSS™

APPLICATION FOR GROUP INSURANCE CONFIRMATION AGREEMENT

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
Group Administrator:	Name	Telephone	Email Address
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	☐	%	%	Optional Life	☐	%	%
AD&D	☐	%	%	Extended Health Care	☐	%	%
Dependent Life	☐	%	%	Dental	☐	%	%
STD (WI)	☐	%	%	Second Opinion	☐	%	%
LTD	☐	%	%	inConfidence EFAP	☐	%	%
Critical Conditions	☐	%	%	HSA	☐	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? _____

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APPLICATION FOR GROUP INSURANCE CONFIRMATION AGREEMENT

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 _____ (Date (yyyy-mmm-dd)) at _____ (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:			

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PRE-AUTHORIZED DEBIT (PAD) AGREEMENT
CATEGORY: BUSINESS

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)

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.

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.

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.

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MEDAVIE BLUE CROSS™

INTERNET SERVICES ACCESS FORM

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
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐

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**

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MEDAVIE BLUE CROSS™

INTERNET SERVICES ACCESS FORM - APPENDIX A

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
			☐	☐	☐	☐	☐	☐

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
			☐	☐	☐	☐	☐	☐

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
			☐	☐	☐	☐	☐	☐

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
			☐	☐	☐	☐	☐	☐

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
			☐	☐	☐	☐	☐	☐

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