MEDAVIE BLUE CROSS™

INFORMATION ON CO-ORDINATION OF BENEFITS

550 SHERBROOKE STREET WEST, SUITE 12, MONTREAL, QC H3A 6T6
TOLL FREE: 1-888-588-1212

PLEASE PRINT ALL INFORMATION

PERSONAL INFORMATION

Employer Name: _____ Group Number: _____ Section Number: _____

Identification Number: _____

Last Name of Insured: _____ First Name: _____

Date of Birth: _____
YYYY/MM/DD

CO-ORDINATION OF BENEFITS

Does your spouse or dependents currently have health or dental benefits under another Group insurance contract? ❑ **Yes** ❑ **No**
❑ Spouse ❑ Child

If **Yes**, please state the type of coverage: DENTAL BENEFITS: ❑ Individual ❑ Family HEALTH BENEFITS: ❑ Individual ❑ Family

Name of your spouse's group insurance provider: _____ Date on which your spouse became eligible for these benefits: _____
YYYY/MM/DD

Contract Number: _____ Certificate Number: _____

If your dependents are insured under another group contract, do you still wish to insure them under your current contract?

❑ **Yes** ❑ Health benefits ❑ Dental benefits ❑ Spouse ❑ Children

❑ **No** (If **No**, please provide the following information):

I wish to waive the following coverage:

DENTAL BENEFITS ❑ For me and my dependents (already insured under another contract) ❑ For my dependents only

HEALTH BENEFITS ❑ For me and my dependents (already insured under another contract) ❑ For my dependents only

Employee's Signature: _____ Date: _____
YYYY/MM/DD