MANITOBA BLUE CROSS®

BRANDON UNIVERSITY

INDIVIDUAL APPLICATION FOR GROUP BENEFITS EMPLOYEES

PO BOX 1046 STN MAIN WINNIPEG MB R3C 2X7
TEL: 204.775.0151 FAX: 204.772.1231

TO BE COMPLETED BY EMPLOYEE

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Employee Last Name

Mailing Address - Street/Box Number

City/Town

Province

Postal Code | Telephone

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Last name, if different from employee *		Gender M/F	Birth Date DD	MM	YYYY	Dependent Status	OTHER PLAN ☑
Employee First Name	00					E - Student (College/University) S - Disabled	☐
Spouse Name	01						☐
Children Name	02						☐
	03						☐
	04						☐
	05						☐

PLEASE INDICATE WHO IS ELIGIBLE UNDER THIS OTHER PLAN

Do you have a Provincial Health Number? ☐ Yes ☐ No

Do you or your dependent have coverage under any other plan? ☐ Yes ☐ No

If YES, please complete the following: Type of plan ☐ Ambulance ☐ Dental ☐ Prescription Drugs ☐ Vision ☐ Health ☐ HSA ☐ Hospital

Name of the Insurance Company _____

* If applicant and spouse are not legally married, please provide commencement date of cohabitation _____

BASIC COVERAGE APPLIED FOR:

Flex Plan: ☐ Option 1 ☐ Option 2 ☐ Option 3 ☐ Option 4 ☑ Life Benefits

☑ All Flex Plan options include Travel

☑ Life
☑ Long Term Disability

- Employees must enroll according to their true family status.
- Once enrolled, employees may not opt out while still employed. (except in the event of duplicate Employer Group Coverage).

WAIVER OF BENEFITS

Health, Dental & Travel can only be waived due to spousal/alternate group coverage.

I have been given the opportunity to apply for coverage but I am choosing to waive coverage due to spousal/alternate group coverage. I understand that I will not be able to enroll in these plans at a later date unless my spousal/alternate group coverage ceases and I notify my employer within 31 days of the termination of coverage.

☐ WAIVE HEALTH, DENTAL & TRAVEL

REASON _____

BENEFICIARY'S LAST NAME	FIRST NAME	RELATIONSHIP	PERCENTAGE (total must equal 100%)
1.			
2.			
3.			

Life Insurance benefits cannot be paid directly to a child under 18. A trustee would have to be appointed to receive these benefits and this could delay payment. You should consider appointing a trustee to receive benefits for any child under age 18.

First and Last Name of Trustee _____ Relationship _____ Phone Number _____

Address of Trustee _____ City _____ Province _____

☐ I certify the above information is true and correct and that all participants are eligible for coverage per the group agreement. I understand that it is my responsibility to notify Manitoba Blue Cross immediately if a participant no longer meets the criteria to remain on my plan. I have read and understood the Authorization & Consent on the reverse side of this form and agree to the conditions of the group agreement between my employer and Manitoba Blue Cross. I hereby confirm the beneficiary designation and authorize payroll deductions if required.

Employee's Signature _____ Date _____

TO BE COMPLETED BY EMPLOYER

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Name of Employer	Group and Roll Number	Employee Class - Life and/or Disability Income	Occupation
Brandon University	**41327**		

• Permanent Date Employed DD	MM	YYYY	Complete for Life and Disability Income Benefits	• Hours Worked/ Week	• Payroll No. (maximum 9 positions)	Flex Plan
			Earnings Per ☐ Hour ☐ Month ☐ Week ☐ Year $ _____			☐ Part-Time ☐ Full-Time
						Union

Completed for Employer by Signature _____ Date _____

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Certificate Number	Group and Roll Number	Province	Status	Type of App.	Mode of Earnings	Occupation Code	Language
	41327		1 3	N A			

Employee Class - Life and/or Disability Income	Effective Date DD	MM	YYYY	Loading Factor WI/CC	LTD	Beneficiary Code	DLIF Code

Blue Cross Life Insurance Company of Canada underwrites all life and disability income benefits.

AUTHORIZATION AND CONSENT

I understand that the personal information and personal health information provided herein as well as any other personal information and personal health information currently held or collected in the future by Manitoba Blue Cross and/or Blue Cross Life Insurance Company of Canada (collectively referred to as "Blue Cross") may be collected, used, or disclosed to administer the terms of the policy of which I am an eligible member, to develop and recommend suitable products and services to me, and to manage the Company's business.

Depending on the type of coverage I carry, limited personal information or personal health information may be collected from and/or released to a third party. These include other Blue Cross organizations, licensed physicians and/or any other healthcare professionals or institutions, health and life insurers, government and regulatory authorities, and other third parties when required to administer the benefits outlined in the policy of which I am an eligible member.

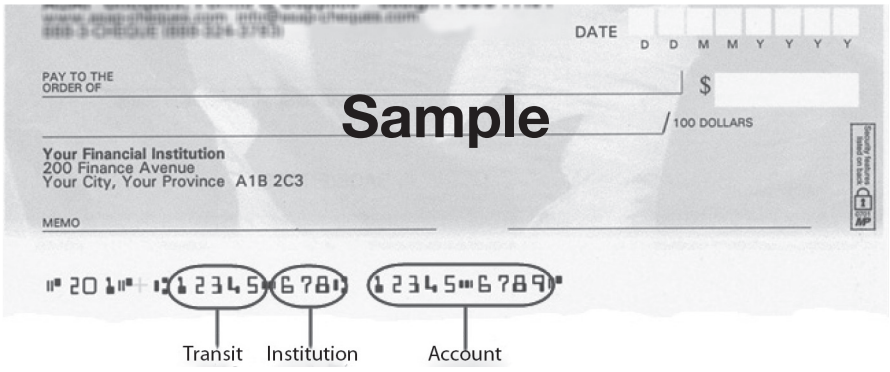
I understand that my personal information and personal health information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, the coverage may be denied or rescinded. I understand why my personal information and personal health information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding Blue Cross' privacy policies as to the collection, use, or disclosure of my information, I may contact Manitoba Blue Cross at 204.775.0151 or at www.mb.bluecross.ca.

I authorize Blue Cross to collect, use and disclose my personal information and personal health information as described above.

Direct Deposit Application

FIRST NAME	LAST NAME	
FINANCIAL INSTITUTION NAME		
BRANCH ADDRESS	CITY	PROVINCE
TRANSIT NUMBER	INSTITUTION NUMBER	ACCOUNT NUMBER

For verification purposes, please enclose a void cheque



I hereby authorize Manitoba Blue Cross to transfer ALL claim payments to the financial institution indicated above.

SIGNATURE	DATE