MANITOBA BLUE CROSS™

P.O. BOX 1046, WINNIPEG, MANITOBA R3C 2X7
TEL: (204) 775-0161 FAX (204) 774-1761

APPLICATION FOR GROUP BENEFITS

THIS SECTION TO BE COMPLETED BY EMPLOYEE

SURNAME	GIVEN NAME AND MIDDLE INITIAL(S)	EMPLOYEE DATE OF BIRTH:	DAY	MONTH	YEAR

ADDRESS- STREET/BOX NUMBER	CITY OR TOWN	PROVINCE	POSTAL CODE

TELEPHONE NUMBER HOME ( )	WORK ( )	GENDER ☐ MALE ☐ FEMALE	PROVINCIAL HEALTH NUMBER

PLEASE COMPLETE THIS SECTION IF YOU HAVE ELIGIBLE DEPENDENTS

☐ SPOUSE ☐ COMMON LAW	SURNAME (IF DIFFERENT THAN EMPLOYEE'S)	GIVEN NAME AND MIDDLE INITIAL	DATE OF BIRTH DAY	MONTH	YEAR	GENDER ☐ MALE ☐ FEMALE

IF APPLICANT AND SPOUSE ARE NOT LEGALLY MARRIED PLEASE PROVIDE COMMENCEMENT DATE OF COHABITATION

UNMARRIED DEPENDENT CHILDREN:

SURNAME (IF DIFFERENT THAN EMPLOYEE)	GIVEN NAME AND MIDDLE INITIAL	RELATIONSHIP	DATE OF BIRTH DAY	MONTH	YEAR	GENDER
						☐ M ☐ F
						☐ M ☐ F
						☐ M ☐ F
						☐ M ☐ F

COVERAGES APPLIED FOR

CHECK (√) THOSE PLANS YOU WISH	☐ AMBULANCE AND HOSPITAL ☐ EXTENDED HEALTH BENEFITS ☐ REIMBURSEMENT DRUGS OR ☐ BLUENET DRUGS	☐ DENTAL SERVICE PLAN	☐ VISION CARE PLAN ☐ EMPLOYEE ASSISTANCE PLAN	☐ EMPLOYEE TRAVEL HEALTH PLAN ☐ HEALTH SPENDING ACCOUNT

- **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 GROUP **COVERAGE**)

DO YOU HAVE COVERAGE FOR ANY OF THE BENEFITS APPLIED FOR THROUGH ANOTHER INSURANCE PLAN? ☐ NO ☐ YES – **IF YES PLEASE INDICATE:**

BENEFITS COVERED ☐ HEALTH ☐ VISION ☐ DENTAL ☐ DRUGS	NAMES OF INSURED	NAME OF INSURANCE COMPANY	POLICY NUMBER

PLEASE COMPLETE THIS SECTION IF YOU ARE WAIVING BENEFITS

I AM WAIVING THE FOLLOWING BENEFITS AS I AM CURRENTLY COVERED THROUGH MY SPOUSE'S PLAN: ☐ HEALTH ☐ DENTAL ☐ TRAVEL ☐ VISION

POLICY NUMBER	NAME OF INSURANCE COMPANY

I CERTIFY THAT ALL THE ABOVE INFORMATION IS CORRECT AND I AGREE TO THE CONDITIONS OF THE GROUP AGREEMENT BETWEEN MY EMPLOYER AND MANITOBA BLUE CROSS. I ALSO AGREE TO THE AUTHORIZATION AND CONSENT ON THE REVERSE SIDE OFTHIS FORM.

EMPLOYEE SIGNATURE:_____ DATE:_____

THIS SECTION IS TO BE COMPLETED BY EMPLOYER

NAME OF GROUP	GROUP AND ROLL NUMBER	DATE OF HIRE ☐ FULL TIME	DAY	MONTH	YEAR

EMPLOYEE NUMBER	OCCUPATION	HOURS WORKED/WEEK	☐ PART TIME			

I HEREBY CERTIFY THIS EMPLOYEE MEETS THE CONTRACTUAL REQUIREMENTS OF BEING AN ELIGIBLE **EMPLOYEE**	COMPLETED FOR EMPLOYER BY	DATE	TELEPHONE

BLUE CROSS USE ONLY

GROUP NUMBER	ROLL	COVERAGE EFFECTIVE DAY	MONTH	YEAR	CONTRACT NUMBER