PO BOX 1046 STN MAIN WINNIPEG MB R3C 2X7
TEL: 204.775.0151 FAX 204.774.1761

WANTE RETIRED EMPLOYEES
APPLICATION FOR GROUP HEALTH BENEFITS

THIS SECTION TO BE COMPLETED BY RETIREE – SEND COMPLETED FORM TO MANITOBA BLUE CROSS

LAST NAME	FIRST NAME	RETIREE DATE OF BIRTH:	DAY	MONTH	YEAR

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

TELEPHONE NUMBER HOME:	GENDER ☐ MALE ☐ FEMALE	DO YOU HAVE A PROVINCIAL HEALTH NUMBER? ☐ YES ☐ NO

DATE OF RETIREMENT:____

WERE YOU COVERED BY THE MANITOBA PUBLIC SCHOOL EMPLOYEES EXTENDED HEALTH BENEFITS PLAN IMMEDIATELY PRIOR TO RETIREMENT?
☐ NO ☐ YES

IF YES, PROVIDE YOUR MANITOBA BLUE CROSS CERTIFICATE NUMBER:_______________________

IF NO, HAVE YOU HAD AT LEAST 5 CONTINUOUS YEARS OF SERVICE IN A SCHOOL DIVISION IMMEDIATELY PRIOR TO RETIREMENT?
☐ NO ☐ YES

PLEASE COMPLETE THIS SECTION IF YOU HAVE ELIGIBLE DEPENDENTS

☐ MARRIED ☐ COMMON LAW	LAST NAME (IF DIFFERENT THAN RETIREE)	FIRST NAME	DATE OF BIRTH DAY	 MONTH	 YEAR	GENDER ☐ MALE ☐ FEMALE

UNMARRIED DEPENDENT CHILDREN:

LAST NAME (IF DIFFERENT THAN RETIREE)	FIRST NAME	RELATIONSHIP	DATE OF BIRTH DAY	 MONTH	 YEAR	GENDER
						☐ M ☐ F
						☐ M ☐ F

- **RETIREES MUST ENROLL ACCORDING TO THEIR TRUE FAMILY STATUS WITHIN 90 DAYS OF RETIREMENT**
- **ONCE ENROLLED, RETIREES MAY NOT OPT OUT EXCEPT IN THE EVENT OF DUPLICATE GROUP COVERAGE**

DO YOU HAVE HEALTH COVERAGE THROUGH BLUE CROSS OR ANOTHER INSURANCE PLAN?
☐ NO ☐ YES – **IF YES PLEASE INDICATE:**

NAMES OF INSURED	NAME OF INSURANCE COMPANY	POLICY NUMBER

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

RETIREE SIGNATURE:_________________________________ **DATE**:____________________

BLUE CROSS USE ONLY

NAME OF GROUP
WANTE RETIRED EMPLOYEES

GROUP NUMBER	**COVERAGE EFFECTIVE** **DAY**	 **MONTH**	 **YEAR**	**CONTRACT NUMBER**

® The Blue Cross symbol and name are registered marks of the Canadian Association of Blue Cross Plans, an association of independent Blue Cross plans. Licensed to the Manitoba Blue Cross Plan.

CONTACT MANITOBA BLUE CROSS WITH ANY QUESTIONS. CONTACT INFORMATION IS ON THE BACK OF THIS BOOKLET.

AUTHORIZATION AND CONSENT

I understand that the personal information provided herein as well as any other personal information currently held or collected in the future by Manitoba Blue Cross may be collected, used, or disclosed to administer the terms of the group 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 may be collected from and/or released to a third party. These third parties include other Blue Cross Plans, health care professionals or institutions, health and life insurers, government and regulatory authorities, and other third parties when required to administer the benefits outlined in my policy or the group policy of which I am an eligible member.

I understand that my personal 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 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 I can contact Blue Cross at 1.800.873.2583 or www.mb.bluecross.ca should I have questions as to the collection, use or disclosure of my personal information.

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

ENJOY THE BENEFITS OF THE MANITOBA BLUE CROSS PRE-AUTHORIZED DEBIT

PRE-AUTHORIZED DEBIT APPLICATION FORM

I/WE HEREBY AUTHORIZE

____
Name of Financial Institution

____
Branch Address

______________________ ______________________
City/Town Province

______________ ______________ ______________
Transit Number Bank Number Account Number

I/We hereby authorize Manitoba Blue Cross to perform a business Pre-Authorized Debit (PAD) on the designated date of every month for each billing period. The amount may vary. I/We will notify Manitoba Blue Cross in writing of any changes to my account information. I/We may revoke my authorization at any time, subject to providing notice of 30 days. For more information on my right to cancel a PAD agreement, I/We may contact my financial institution or visit www.cdnpay.ca. I/We have certain recourse rights if any debit does not comply with this agreement. To obtain more information on my recourse rights, I/We may contact my financial institution or visit www.cdnpay.ca

This authorization may be cancelled at any time upon written notice by me/us. For a joint account, all depositors must sign if more than one signature is required on cheques issued against the account.

PLEASE ENCLOSE ONE OF YOUR CHEQUES MARKED "VOID" FOR VERIFICATION PURPOSES.

Date______________________ Signature(s) ______________________

____