MANITOBA BLUE CROSS®

PO BOX 1046 STN MAIN WINNIPEG MB R3C 2X7
TEL 204.775.0161 Fax 204.774.1761

MANITOBA PUBLIC SCHOOL EMPLOYEES WANTE RETIREES 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	DD MM YYYY

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

PHONE NUMBER HOME CELL	GENDER ❑ MALE ❑ FEMALE	DO YOU HAVE A PROVINCIAL HEALTH NUMBER? ❑ YES ❑ NO

DATE OF RETIREMENT

DD MM YYYY

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

IF YES, PROVIDE YOUR MANITOBA BLUE CROSS CERTIFICATE NUMBER:

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

PLEASE COMPLETE THIS SECTION IF YOU HAVE ELIGIBLE DEPENDENTS

❑ MARRIED ❑ COMMON LAW	LAST NAME (if different than Retiree's)	FIRST NAME	DATE OF BIRTH DD MM YYYY	GENDER ❑ MALE ❑ FEMALE

IF APPLICANT AND SPOUSE ARE NOT LEGALLY MARRIED PLEASE PROVIDE COMMENCEMENT DATE OF COHABITATION (DD/MM/YYYY)_____

UNMARRIED DEPENDENT CHILDREN:

LAST NAME (if different than Retiree's)	FIRST NAME	RELATIONSHIP	DATE OF BIRTH DD	MM	YYYY	GENDER ❑ MALE ❑ FEMALE
						❑ MALE ❑ FEMALE
						❑ MALE ❑ FEMALE

- **RETIREES MUST ENROLL ACCORDING TO THEIR TRUE FAMILY STATUS WITHIN 90 DAYS OF RETIREMENT.**
- **IF A RETIREE LEAVES THE PLAN ONCE ENROLLED, THERE IS NO REJOINING THE PLAN AT A LATER DATE.**

DO YOU OR YOUR DEPENDENTS HAVE COVERAGE FOR ANY OF THE BENEFITS APPLIED FOR THROUGH ANOTHER INSURANCE PLAN? ❑ YES ❑ NO

IF YES, PLEASE INDICATE

NAME OF INSURED	NAME OF INSURANCE COMPANY	POLICY NUMBER

❑ I certify the above information is true and correct and agree to the conditions of 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 former employer and Manitoba Blue Cross.

RETIREE SIGNATURE_____ DATE_____

BLUE CROSS USE ONLY

GROUP NUMBER	ROLL	COVERAGE EFFECTIVE (DD/MM/YYYY)	CERTIFICATE NUMBER
7133	225		

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.

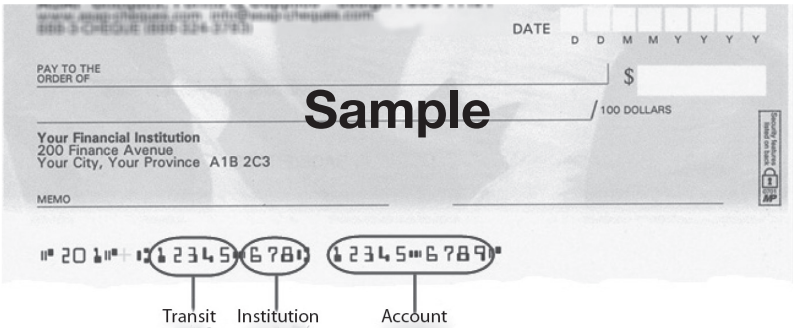
I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, the coverage may be denied or rescinded. I understand why my personal information is needed and am aware of the risks and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

Pre-Authorized Debit Agreement

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.

AUTHORIZED SIGNATURE	DATE

I authorize Manitoba Blue Cross to perform a personal Pre-Authorized Debit (PAD) on the first of every month for each billing period. The amount may vary. I will notify Manitoba Blue Cross in writing of any changes to my account information. I 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 may contact my financial institution or visit www.cdnpay.ca. I have certain recourse rights if any debit does not comply with this agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.