MANITOBA SCHOOL EMPLOYEES BENEFIT PLANS

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One Lombard Place, Suite 1410
Winnipeg, MB R3B 0X5

MANITOBA PUBLIC SCHOOL EMPLOYEES
RETIREE APPLICATION FOR GROUP HEALTH AND DENTAL BENEFITS

THIS SECTION TO BE COMPLETED BY RETIREE - SEND COMPLETED FORM TO mpse.retirees@mercer.com (FAX or MAIL also accepted).

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 ☐ UNDISCLOSED ☐ FEMALE ☐ OTHER	DO YOU HAVE A PROVINCIAL HEALTH NUMBER? ☐ YES ☐ NO

RETIREE PERSONAL EMAIL ADDRESS	DATE OF RETIREMENT DD MM YYYY	SCHOOL DIVISION

ARE YOU AT LEAST 50 YEARS OLD AT THE TIME OF APPLICATION? ☐ YES ☐ NO

WERE YOU EMPLOYED FOR AT LEAST 5 CONSECUTIVE YEARS IN A PUBLIC SCHOOL DIVISION IMMEDIATELY PRIOR TO RETIREMENT? (CASUAL EMPLOMENT IS NOT INCLUDED) ☐ YES ☐ NO

CHECK (✓) THE OPTIONS YOU WISH ☐ OPTION 1 - HEALTH ONLY ☐ OPTION 2 - DENTAL ONLY ☐ OPTION 3 - HEALTH AND DENTAL

You are only eligible for Option 2 (Dental only) if proof of alternate employer-administered group Health coverage is provided.

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

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

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

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 ☐ UNDISCLOSED ☐ FEMALE ☐ OTHER

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 ☐ UNDISCLOSED ☐ FEMALE ☐ OTHER
				☐ MALE ☐ UNDISCLOSED ☐ FEMALE ☐ OTHER
				☐ MALE ☐ UNDISCLOSED ☐ FEMALE ☐ OTHER

- **YOU MUST ENROLL ACCORDING TO YOUR TRUE FAMILY STATUS WITHIN 90 DAYS OF RETIREMENT.**
- **ONCE ENROLLED, YOU WILL NOT BE ABLE TO OPT OUT OF EITHER HEALTH OR DENTAL WITHOUT TERMINATING BOTH COVERAGES.**
- **IF YOU LEAVE THE PLAN ONCE ENROLLED, YOU CANNOT REJOIN THE PLAN AT A LATER DATE UNLESS YOU'VE LOST ALTERNATE EMPLOYER-ADMINISTERED GROUP COVERAGE.**

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

IF YES, PLEASE INDICATE ☐ HEALTH ☐ DENTAL

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 have read and understood the Authorization & Consent on the reverse side of this form and agree to the conditions of the group agreement between Manitoba Blue Cross and the Manitoba Public School Employees Benefits Trust.

RETIREE SIGNATURE _____ DATE _____

BLUE CROSS USE ONLY

GROUP NUMBER	ROLL	COVERAGE EFFECTIVE (DD/MM/YYYY)	CERTIFICATE NUMBER
7133	119		

MANITOBA BLUE CROSS®

MANITOBA BLUE CROSS 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 Manitoba Blue Cross may retain service providers inside and outside of Canada to assist them in their business and further understand that my personal information may be subject to disclosure to law enforcement and other authorities, where required by law, both inside and outside of Canada, when such information is in the possession of Manitoba Blue Cross or one of its authorized service providers.

I understand that I have provided my consent for Manitoba Blue Cross to collect, use and disclose my personal information as outlined in the Manitoba Blue Cross Privacy Code. 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 or for questions as to the collection, use or disclosure of my personal information, I can contact Manitoba Blue Cross at 204.775.0151 or 1.800.873.2583 or mb.bluecross.ca.

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

MANITOBA PUBLIC SCHOOL EMPLOYEES AUTHORIZATION AND CONSENT

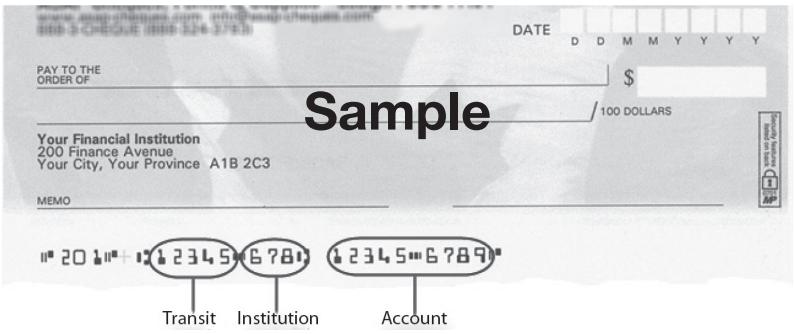
By providing my signature directly below this paragraph, I further consent to Mercer (Canada) Limited collecting and using my contact information including my email address for the purpose of providing me with periodic newsletters, updates and/or information integral to the group policy of which I am a member. I also consent to Mercer (Canada) Limited disclosing my information to the Manitoba Public Schools Employees Benefits Trust for the purpose of providing me with periodic newsletters, updates and/or information integral to the group policy of which I am a member.

RETIREE SIGNATURE _____ DATE _____

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



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.