MANITOBA BLUE CROSS®

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

MANITOBA PUBLIC SCHOOL EMPLOYEES EXTENDED HEALTH BENEFITS PLAN FOR NEW APPLICANTS

ONE TIME OPPORTUNITY FOR NEW HIRES TO ENROLL OR WAIVE WHEN COVERAGE NOT COMPULSORY

THIS SECTION TO BE COMPLETED BY EMPLOYEE

LAST NAME	FIRST NAME	EMPLOYEE DATE OF BIRTH (DD MM YYYY)

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

PHONE NUMBER HOME WORK	EMAIL ADDRESS	GENDER ☐ MALE ☐ UNDISCLOSED ☐ FEMALE ☐ OTHER	PROVINCIAL HEALTH NUMBER? ☐ YES ☐ NO

ENROLLMENT SECTION

PLEASE COMPLETE THIS SECTION IF YOU HAVE ELIGIBLE DEPENDENTS

☐ MARRIED ☐ COMMON LAW	LAST NAME (if different than employee'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 employee's)	FIRST NAME	RELATIONSHIP	DATE OF BIRTH (DD MM YYYY)	GENDER ☐ MALE ☐ UNDISCLOSED ☐ FEMALE ☐ OTHER
				☐ MALE ☐ UNDISCLOSED ☐ FEMALE ☐ OTHER
				☐ MALE ☐ UNDISCLOSED ☐ FEMALE ☐ OTHER
				☐ MALE ☐ UNDISCLOSED ☐ FEMALE ☐ OTHER

- **EMPLOYEES MUST ENROLL ACCORDING TO THEIR TRUE FAMILY STATUS.**
- **ONCE ENROLLED, EMPLOYEES MAY NOT OPT OUT WHILE STILL EMPLOYED (EXCEPT IN THE EVENT OF ALTERNATE EMPLOYER-ADMINISTERED GROUP COVERAGE).**

DO YOU HAVE COVERAGE FOR ANY OF THE BENEFITS APPLIED FOR THROUGH ANOTHER INSURANCE PLAN? ☐ YES ☐ NO - IF YES, PLEASE COMPLETE THE FOLLOWING

TYPE OF PLAN ☐ HEALTH	NAME OF INSURED	NAME OF INSURANCE COMPANY

WAIVER SECTION

PLEASE COMPLETE THIS SECTION IF YOU ARE WAIVING BENEFITS

I AM WAIVING THE FOLLOWING BENEFITS ☐ HEALTH

* **I UNDERSTAND THAT BY WAIVING BENEFITS, I WILL NOT BE ALLOWED TO JOIN THE PLAN IN THE FUTURE UNLESS IT IS DUE TO THE LOSS OF ALTERNATE EMPLOYER-ADMINISTERED GROUP COVERAGE OR A LIFE EVENT**

☐ 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.

EMPLOYEE SIGNATURE _____ DATE _____

THIS SECTION TO BE COMPLETED BY EMPLOYER

NAME OF DIVISION	GROUP AND ROLL NUMBER	DATE OF HIRE (DD MM YYYY) ☐ FULL TIME

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 (DD/MM/YYYY)	TELEPHONE

BLUE CROSS USE ONLY

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

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 the 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 (including the determination of eligibility for insurance coverage, benefits and services and for processing and settling claims) 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 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 the policy of which I am an eligible member. I understand that Blue Cross may retain service providers inside and outside of Canada to assist them in their business and further understand that my personal information or personal health 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 Blue Cross or one of its authorized service providers.

I understand that I have provided my consent for Blue Cross to collect, use and disclose my personal information or personal health information as outlined in the 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.

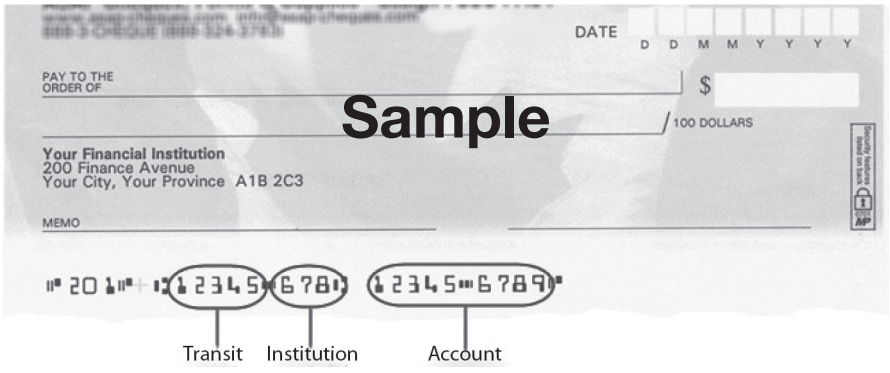
I understand why my personal information and personal health information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding Blue Cross's privacy policies or for questions as to the collection, use or disclosure of my personal information, I can contact Blue Cross at 204.775.0151 or 1.800.873.2583 or visit 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