



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

**MANITOBA PUBLIC SERVICE RETIREE HEALTH PLAN
 RETIREE 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		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		PROVINCIAL HEALTH NUMBER? <input type="checkbox"/> YES <input type="checkbox"/> NO			

PLEASE COMPLETE THIS SECTION IF YOU HAVE ELIGIBLE DEPENDENTS

<input type="checkbox"/> SPOUSE	LAST NAME (if different than Retiree)	FIRST NAME	DATE OF BIRTH			GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
<input type="checkbox"/> COMMON LAW			DD	MM	YYYY	

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)	FIRST NAME	RELATIONSHIP	DATE OF BIRTH			GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
			DD	MM	YYYY	
						<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
						<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
						<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE

DATE OF RETIREMENT: _____

MANITOBA GOVERNMENT DEPARTMENT OR CROWN CORPORATION WHERE I WAS EMPLOYED PRIOR TO RETIREMENT: _____

PLEASE PLACE A CHECK MARK IN THE APPROPRIATE SPACE BESIDE YOUR SELECTED COVERAGE:

	SINGLE	COUPLE	FAMILY
OPTION 1 HEALTH (ambulance, hospital)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OPTION 2 HEALTH (ambulance, hospital, extended health)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OPTION 3 HEALTH & DENTAL (ambulance, hospital, extended health, vision, dental)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OPTION 4 ENHANCED HEALTH & DENTAL (ambulance, hospital, extended health, vision, dental)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- RETIREEES MUST ENROLL ACCORDING TO THEIR TRUE FAMILY STATUS
- ONCE YOU ARE ENROLLED IN THIS PLAN, YOU ARE PERMITTED TO REDUCE BENEFITS BY CHANGING YOUR OPTION

ARE YOU PRESENTLY COVERED BY BLUE CROSS? NO YES

DO YOU HAVE COVERAGE FOR ANY OF THE BENEFITS APPLIED FOR THROUGH ANOTHER INSURANCE PLAN?
 NO YES - IF YES, PLEASE INDICATE BELOW:

BENEFITS COVERED <input type="checkbox"/> HEALTH <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION <input type="checkbox"/> DRUGS <input type="checkbox"/> AMBULANCE & HOSPITAL	NAME OF INSURED	NAME OF INSURANCE COMPANY
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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.

RETIREE SIGNATURE _____ DATE _____

BLUE CROSS USE ONLY

NAME OF GROUP MANITOBA PUBLIC SERVICE RETIREE HEALTH PLAN		
GROUP NUMBER 7640	COVERAGE EFFECTIVE (DD/MM/YYYY)	CERTIFICATE NUMBER

SEE THE REVERSE SIDE OF THIS FORM FOR PRE-AUTHORIZED DEBIT INFORMATION.

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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 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 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 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 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 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 MONTHLY DEBIT APPLICATION

FIRST NAME		LAST NAME	
MAILING ADDRESS			
CITY	PROVINCE	POSTAL CODE	
EMAIL			
PHONE NUMBERS - HOME	BUSINESS	CELL	

FINANCIAL INSTITUTION INFORMATION

FINANCIAL INSTITUTION NAME		
TRANSIT NUMBER	INSTITUTION NUMBER	ACCOUNT NUMBER

Please include a void cheque



Pre-Authorized Debit Agreement

I 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 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.**

Authorized Signature	DATE
Second Authorized Signature (if required)	DATE

PLEASE INCLUDE ALL SIGNATURES REQUIRED FOR CHEQUE ENDORSEMENT

