TRV

MANITOBA BLUE CROSS®

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
UNDER AGE 75

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 ☐ MALE ☐ FEMALE	PROVINCIAL HEALTH NUMBER? ☐ YES ☐ NO

PLEASE COMPLETE THIS SECTION IF YOU HAVE ELIGIBLE DEPENDENTS

☐ SPOUSE ☐ COMMON LAW	LAST NAME (if different than Retiree)	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)	FIRST NAME	RELATIONSHIP	DATE OF BIRTH DD	MM	YYYY	GENDER ☐ MALE ☐ FEMALE
						☐ MALE ☐ FEMALE
						☐ MALE ☐ FEMALE

DATE OF RETIREMENT: _____

MANITOBA PUBLIC SECTOR EMPLOYER 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)	☐	☐	☐
OPTION 2 HEALTH (ambulance, hospital, extended health, travel)	☐	☐	☐
OPTION 3 HEALTH & DENTAL (ambulance, hospital, extended health, travel, vision, dental)	☐	☐	☐
OPTION 4 ENHANCED HEALTH & DENTAL (ambulance, hospital, extended health, travel, vision, dental)	☐	☐	☐

- **RETIREES MUST ENROLL ACCORDING TO THEIR TRUE FAMILY STATUS**
- **ONCE ENROLLED IN THIS PLAN, YOU ARE ONLY PERMITTED TO REDUCE BENEFITS ON JANUARY 1ST IF YOU HAVE BEEN ENROLLED IN YOUR CURRENT OPTION FOR AT LEAST 12 MONTHS**
- **APPLICATIONS MUST BE SUBMITTED TO MANITOBA BLUE CROSS WITHIN 60 DAYS OF YOUR RETIRMENT DATE**
- **COVERAGE IS EFFECTIVE THE 1ST OF THE MONTH FOLLOWING YOUR RETIREMENT DATE**

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	NAME OF INSURED	NAME OF INSURANCE COMPANY
☐ HEALTH ☐ DENTAL ☐ VISION ☐ DRUGS ☐ AMBULANCE & HOSPITAL		

☐ 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

HOW TO SUBMIT THIS FORM

Mail:	Attention: Client Administration PO Box 1046 Stn Main Winnipeg, MB R3C 2X7	In Person:	599 Empress Street, Winnipeg, MB
Fax:	Attention: Client Administration 204.772.1231	Email:	MBCgroupbenefits@mb.bluecross.ca

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

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.

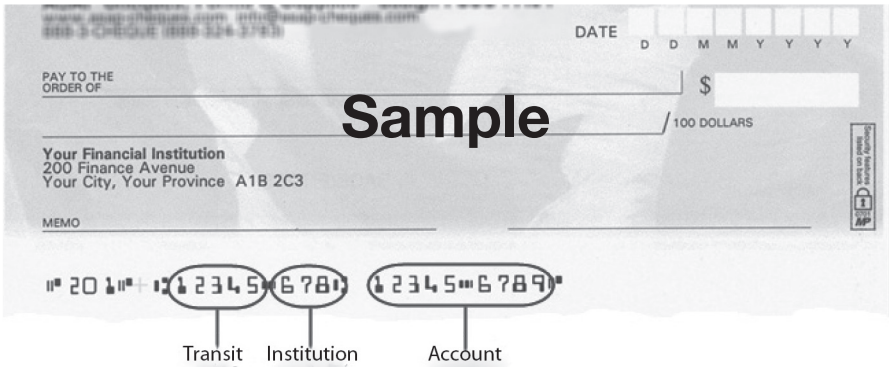
PRE-AUTHORIZED MONTHLY DEBIT APPLICATION

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