

RETIREE APPLICATION FOR GROUP HEALTH BENEFITS

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

THIS SECTION TO BE COMPLETED BY RETIREE - SEND COMPLETED FORM TO MANITOBA BLUE CROSS

LAST NAME			FIRST NAM	ИЕ			RETIRE DATE O	E IF BIRTH	DD	MM	
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UNMARRIED DEPENDE	ENT CHILDREN:										
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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that I may revoke my consent at any time; however, if consent is withheld or revoked, the coverage may be denied or rescinded.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

RANSIT NUMBER	INSTITUTION NUMBER	ACCOUNT NUMBER
Please include a	www.asspollague.com.intr@www.ohegue.com 888.5 OrEOut 1896-324-3783)	DATE D D M M Y Y Y
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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

