

PROVINCE OF MANITOBA APPLICATION FOR VOLUNTARY HEALTH BENEFITS

Last Name		First Name		Employee Date of Birth		DD	MM	YYYY
Mailing Address - Street/Box Number				City or Town		Province		Postal Code
Phone Number				Gender		Provincial Health Number		
Home Work				Male Female		YES NO		

Spouse	Last Name	First Name	Date of Birth			Gender
Common Law			DD	MM	YYYY	
						Male
						Female

[illegible]

Coverage Applied For:

Check (✓) those plans you wish	Ambulance and Hospital	Extended Health	Travel
<ul style="list-style-type: none">Employees must enroll according to their true family status.Once enrolled, employees may not opt out while still employed (except in the event of duplicate employer group coverage).If you enroll in extended health, you must also enroll in ambulance and hospital.			

Do you or your dependents have coverage for any of the benefits applied for through another insurance plan yes no - if yes, please indicate

Benefits Covered	Name of Insured	Name of Insurance Company
Health Dental Ambulance		
HSA Drugs Hospital		
Vision		

Please complete this Section if you are waiving benefits.

I am waiving the following benefits	Ambulance & Hospital	Extended Health	Travel
Policy Number	Name of Insurance Company		

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 Employer		Group and Roll Number		Date of Hire	DD	MM	YYYY
Province of Manitoba				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

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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.

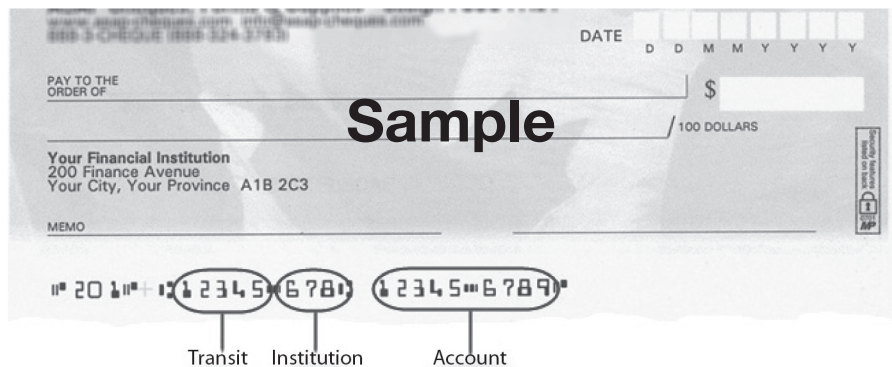
I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding Manitoba Blue Cross's privacy policies I can contact Manitoba Blue Cross at 204.775.0151 or 1.800.873.2583 or Manitoba Blue Cross Website 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.

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
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