MEDAVIE BLUE CROSS

GROUP INSURANCE APPLICATION

Please Print

IMPORTANT: This Group Insurance Application form is ONLY for eligible CN Defined Contribution (CNDC) Retirees who DO NOT have a CN DB monthly pension sufficient to cover the premiums under any other Health Care Plans sponsored by the CN Pensioners Association. In addition to this Application Form, you must include documentation from CN confirming your PIN, Date of Birth, Years of CN Employment & Date of Termination from CN. Your effective date for coverage is the 1st of the month following termination of CN employment.

Quebec - Those persons 65 years of age or older have access to this group benefits plan and may enroll in this plan in addition to or in lieu of RAMQ coverage. Those UNDER age 65 should enroll in RAMQ coverage if they are not eligible to another group benefits plan.

1. RETIREE PIN & EFFECTIVE DATE OF COVERAGE

HEALTH CARE PLAN for CNDC Retirees - Contract: 91526 - _____ (leave blank)

PIN_____ **Effective Date (YYYY/MM/DD):** _____

2. RETIREE & DEPENDENT INFORMATION

Option: ☐ B ☐ C3 ☐ D **Type of Plan:** ☐ Individual ☐ Family

Last Name of Insured: _____ First Name: _____

Sex*: ☐ Male ☐ Female ☐ Intersex ☐ Undisclosed Language Preferred: ☐ English ☐ French

Date of Birth (YYYY/MM/DD): _____ Address (Street & Number): _____

City/Town: _____ Province of Residence: _____ Postal Code: _____

Telephone Number: _____ Email Address: _____

Status: ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Common-Law Spouse

NOTE: If you checked the "Common-Law Spouse", please indicate the start date of co-habitation (YYYY/MM/DD):_____

* Sex: Male/Female/Intersex/Undisclosed – *Why do we ask?* Some health conditions are more likely to occur based on sex. As a result, sex is used to assess your coverage. We recognize that your sex may differ from your gender identity.

Dependent Information

	Last Name	First Name	Date of Birth (YYYY/MM/DD)	Sex M/F/I/U	Dependent Status
Spouse				☐ Male ☐ Intersex ☐ Female ☐ Undisclosed	
Child				☐ Male ☐ Intersex ☐ Female ☐ Undisclosed	☐ Disabled ☐ Student - College/University
Child				☐ Male ☐ Intersex ☐ Female ☐ Undisclosed	☐ Disabled ☐ Student - College/University

OTHER COVERAGE (CO-ORDINATION OF BENEFITS)

Do you or any of your dependents have coverage under any other Plan? ☐ Yes ☐ No (If No go to Section 3)

If Yes, Complete the following:

☐ For Spouse ☐ For Dependent **Type of Coverage:** ☐ Individual ☐ Family

Name of the Other Insurer:_____

Effective Date of Coverage (DD/MM/YYYY):

Policy Number:_____ ID Number:_____

If your dependents currently have coverage under another group plan, do you still want to purchase coverage for them under this plan?
☐ Yes ☐ No

Name of Person (s) insured under other policy	Date of Birth		
	YYYY	MM	DD

Please Print

3. DIRECT DEBIT OF PREMIUMS AND DIRECT DEPOSIT OF CLAIMS REIMBURSMENTS

Monthly Premiums are deducted directly from your Bank Account and claims reimbursements are deposited directly to your Bank Account. Please Enclose a Blank Cheque Marked Void.

4. AUTHORIZATION

I hereby declare that the information I have provided is accurate. I authorize Medavie Blue Cross to deduct any applicable premiums from my Bank Account.

Signature (Mandatory): _____

Date (YYYY/MM/DD) _____

5. PRIVACY CONSENT

I understand that the personal information provided herein, as well as any other personal information currently held or collected in the future by Medavie Blue Cross may be collected, used, or disclosed to administer the terms of my policy or the group policy of which I am an eligible member, to recommend suitable products and services to me, and to manage Blue Cross'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 organizations, health care professionals or institutions, health insurers, government and regulatory authorities, and other third parties when required to administer and manage the benefits outlined in the policy of which I am an eligible member.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time, however, in some instances doing so may prevent Blue Cross from providing me with the requested coverage or benefits. I understand why my personal information is needed and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure.

A photocopy of this authorization shall be as valid as the original. This consent complies with federal and provincial privacy laws. For additional information regarding privacy policies at Medavie Blue Cross, visit medaviebc.ca or call 1-866-660-7670.

Signature (Mandatory): _____

Address:
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