PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

FIR LR

# ENROLLMENT APPLICATION FOR GROUP BENEFITS

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | Fax: 604 419-2149 | enrollment@pac.bluecross.ca

**MEMBERS — Please complete Parts 2 and 4 of this application and only complete Part 3 if applicable. NOTE: There is no provision to waive coverage. Full participation in the plan is to be a condition of employment for all eligible employees.**
**EMPLOYERS/PLAN ADMINISTRATORS — Please complete Parts 1 and 5 of this application.**
PLEASE PRINT CLEARLY, sign, date and submit your application as soon as possible.

☐ New member ☐ Reinstatement

## PART 1 — EMPLOYER/PLAN ADMINISTRATOR

| Policy number | Name of company/organization | Member ID number |
|---|---|---|
| 8944 | | |

| Extended Health Care effective date (mm-dd-yyyy) | Dental Care effective date (mm-dd-yyyy) |
|---|---|
| | |

| Division | Sub-division (if applicable) | Class | Plan Code (if applicable) |
|---|---|---|---|
| 1 | | 10 | |

| Member's occupation | Employment type |
|---|---|
| | ■ Full-time |

| Date of full-time hire or rehire (mm-dd-yyyy) | Hours per week |
|---|---|
| | |

| If we have questions, how can we contact you? | Telephone (10 digits) | Email address |
|---|---|---|
| | | |

## PART 2 — MEMBER/DEPENDENT INFORMATION

| Legal first name | Preferred name | Last name | Middle initial | Birthdate (mm-dd-yyyy) | Sex |
|---|---|---|---|---|---|
| | | | | | ☐ M ☐ F |

| Street address | City | Province | Postal code |
|---|---|---|---|
| | | | |

Email address

Please provide the information requested in the table below. List any additional children in *Part 3 – Additional Information* section. Please list all your dependents.

| FIRST NAME | LAST NAME | MIDDLE INITIAL | BIRTHDATE (MM-DD-YYYY) | SEX | RELATIONSHIP TO YOU | FULL TIME STUDENT* | SCHOOL NAME + STUDENT NUMBER* |
|---|---|---|---|---|---|---|---|
| Spouse | | | | ☐ M ☐ F | ☐ Common-Law ☐ Married | | |
| First child | | | | ☐ M ☐ F | | ☐ Yes ☐ No | |
| Second child | | | | ☐ M ☐ F | | ☐ Yes ☐ No | |
| Third child | | | | ☐ M ☐ F | | ☐ Yes ☐ No | |
| Fourth child | | | | ☐ M ☐ F | | ☐ Yes ☐ No | |

*Complete this section if child is over the maximum age as stated in your Group Benefit Contract and attending school full-time.
**If you have a child with a disability, include a *Disabled Dependent Application Form*. (Available through your Plan Administrator) Their coverage will be continued beyond the minor maximum age if certain criteria are met.

## PART 3 — ADDITIONAL INFORMATION

## PART 4 — MEMBER SIGNATURE

I agree to the conditions my benefit plan between my employer/plan administrator and Pacific Blue Cross and authorize my employer to deduct the required contributions from my earnings. I confirm that the information I have provided is true and complete.

If I should receive a settlement or a judgement against a liable third party for wage loss or benefits covered under my group plan, I agree to and authorize the third party to reimburse Pacific Blue Cross up to the amount advanced to me pending such settlement or judgement.

I consent to Pacific Blue Cross collecting, using and disclosing my personal information where reasonably necessary for the purposes of my enrollment or coverage under this group plan. I consent to the disclosure of my personal information to agents and representatives of Pacific Blue Cross and other providers/insurers and their agents and representatives for the purposes of assessing and providing benefits coverage. I also consent to the disclosure of my personal information to my employer/plan administrator when required or permitted by law or by contract between Pacific Blue Cross and my employer/plan administrator; and to the retention, use and disclosure of my personal information in accordance with the Pacific Blue Cross privacy policy.

The privacy policy is available online at www.pac.bluecross.ca or by calling Pacific Blue Cross at 604 419-2000.

| Member's signature<br>**X** | Date (mm-dd-yyyy) |
|---|---|

## PART 5 — EMPLOYER/PLAN ADMINISTRATOR SIGNATURES

| Employer/Plan administrator's signature<br>**X** | Employer/Plan administrator's full name and title (print) | Date (mm-dd-yyyy) |
|---|---|---|