

644 MAIN ST PO BOX 220 MONCTON NB E1C 8L3
230 BROWNLOW AVE DARTMOUTH PO BOX 2200 HALIFAX NS B3J 3C6
TEL 1-800-667-4511 FAX 506-867-4651

FOR ALL INQUIRIES:

Administrator, C/O East Coast Care, PO Box 7033, Beresford NB E8K 3X7
Tel: 1-506-545-6644 Toll Free: 1-888-245-3211 Fax: 1-506-546-6644

Instructions

- 1) Please fill in ALL required fields.
- 2) Dependent status: E - Education, if dependent child is attending an accredited school, college or university
S - Special, if dependent child is physically or mentally disabled

If you now have Medavie Blue Cross Benefits, please indicate :Policy Number: ID Number: **Application for Benefits**Coverage Applied for: Single FamilyBasic Coverage Applied For: Health DentalLanguage Preference: English French**TO BE COMPLETED BY APPLICANT**Last Name: Address Street & No.: City or Town: Province: Postal Code: Telephone Number (Please include area code): **INDIVIDUAL REGISTRATION****Member:**First Name: Initial: Surname (If different from member*): Sex: Male FemaleBirth Date (DD/MM/YY): **Spouse:**First Name: Initial: Surname (If different from member*): Sex: Male FemaleBirth Date (DD/MM/YY): **Children:**First Name: Initial: Surname (If different from member*): Sex: Male FemaleBirth Date (DD/MM/YY): Dependent Status E – Student (College/University) S – Disabled: **Children:**First Name: Initial: Surname (If different from member*): Sex: Male FemaleBirth Date (DD/MM/YY): Dependent Status E – Student (College/University) S – Disabled: **Children:**First Name: Initial: Surname (If different from member*): Sex: Male FemaleBirth Date (DD/MM/YY): Dependent Status E – Student (College/University) S – Disabled: * IF MEMBER AND SPOUSE ARE NOT LEGALLY MARRIED, PLEASE PROVIDE COMMENCEMENT DATE OF CO-HABITATION:



APPLICATION FOR GROUP BENEFITS (HEALTH AND DENTAL)

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OTHER COVERAGE

Do you or any of your dependents have other coverage under any other Insurer? [] Yes [] No If Yes, complete the following:

Name of the Other Insurer: [] Effective Date of Coverage: []

ID Number/Certificate Number: [] Policy Number: []

Is the Other Coverage Single Coverage or Family Coverage? Please indicate under "Type of Coverage" S for Single or F for Family for the applicable benefits.

Type of Coverage:

All [] Hospital [] Extended Health Benefits [] Vision [] Drugs [] Dental []

WAIVER OF BENEFITS - I have been given the opportunity to apply for coverage but do not wish to participate, and understand that I will not be able to enrol in these plans at a later date without the mutual consent of my employer and Medavie Blue Cross.

[] Waive Only [] Waive all Benefits

Reason: []

Employee Signature: [] Date: []

I authorize Blue Cross to collect, use and disclose my personal information.

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 and/or Blue Cross Life Insurance Company of Canada, 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.

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.

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 www.medavie.bluecross.ca or call 1-800-667-4511.

Member Signature: [] Date: []

TO BE COMPLETED BY ADMINISTRATOR

Name of Association: [] Policy and Section Number: [] Class of Coverage - Health and/or Dental: []

Occupation: [] Coverage Effective Date (DD/MM/YY): []

Date of membership (DD/MM/YY): [] Hours worked / Week []

Payroll No.: []

Submitted Electronically on (DD/MM/YY): []

ID NUMBER: []