

INDIVIDUAL APPLICATION FOR GROUP INSURANCE PLAN

TO BE COMPLETED BY EMPLOYEE

<p>51</p> <p>Employee's Name _____</p> <p>Gender M/F _____</p> <p>Date of Birth _____</p> <p>BASIC LIFE COVERAGE (Mandatory)</p> <p><input type="checkbox"/> Option 1 – <u>2x Annual Earnings</u> minimum \$16,000, maximum \$700,000</p> <p><input type="checkbox"/> Option 2 – <u>1x Annual Earnings</u> minimum \$8,000, maximum \$700,000</p>	<p>52</p> <p>Address - City/Town _____</p> <p>Postal Code _____</p> <p>Phone Number _____</p> <p>53</p> <p>Optional Life Coverage - Employee Only Only those employees who elected Basic Life Option 1 may apply:</p> <p><input type="checkbox"/> Option 1 – <u>2 x Annual Earnings</u> Maximum \$300,000</p> <p><input type="checkbox"/> Option 2 – <u>1 x Annual Earnings</u> Maximum \$300,000</p> <p><input type="checkbox"/> I DO NOT wish to apply</p>																																						
<p>IF APPLICANT AND SPOUSE ARE NOT LEGALLY MARRIED PLEASE PROVIDE COMMENCEMENT DATE OF COHABITATION _____</p>																																							
<p>FAMILY LIFE COVERAGE (The Employee is the beneficiary of the Insured spouse and children)</p> <p><input type="checkbox"/> NO <input type="checkbox"/> YES</p>																																							
<p>If you have chosen YES to Family Life Coverage please complete this section:</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2">Name</th> <th rowspan="2">Gender M/F</th> <th colspan="3">BIRTH DATE</th> <th rowspan="2">Dependent Status</th> </tr> <tr> <th>DD</th> <th>MM</th> <th>YYYY</th> </tr> </thead> <tbody> <tr> <td>Spouse</td> <td></td> <td></td> <td></td> <td></td> <td rowspan="2">E - Student (College/University) S - Disabled</td> </tr> <tr> <td>Children</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td> </td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td> </td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td> </td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Name	Gender M/F	BIRTH DATE			Dependent Status	DD	MM	YYYY	Spouse					E - Student (College/University) S - Disabled	Children																						
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BENEFICIARY'S LAST NAME	FIRST NAME	INITIAL	RELATIONSHIP	PERCENTAGE
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____

Secondary Beneficiary – Applicable if the primary beneficiary (es) predeceases employee.

Beneficiary Last Name	First Name	Initial	Relationship	Percentage
_____	_____	_____	_____	_____

I certify that all information contained herein is correct, and hereby confirm the beneficiary designation and authorize payroll deductions if required. I also agree to the Authorization and Consent on the reverse site of this form.

Designate a trustee for minor beneficiary _____

Employee's Signature _____ Date _____

TO BE COMPLETED BY EMPLOYER

54			Name of Employer _____				Employer Number _____		Group Number 41380		Employee Class - Life _____		Occupation _____	
• Date Employed			Total Yearly Coverage Amount				Completed for Employer by							
DD	MM	YYYY	\$ _____				Signature _____ Date _____							

FOR BLUE CROSS USE ONLY

55		Contract Number _____		Group and Roll Number _____		Province _____		Status 1 3		Type of App. N A		Mode of Earnings _____		Occupation Code _____		Language _____	
Employee Class - Life _____				Effective Date DD MM YYYY		NEXUS Code _____		Loading Factor WI/CC LTD				Ben. Code _____		DLIF Code _____			



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.