APPLICATION FOR GROUP BENEFITS

Mailing Address:
PO Box 7000, Vancouver, BC V6B 4E1
Street Address:
4250 Canada Way, Burnaby, BC
Fax: 604 419-2149

for PBC office use only

❑ New Applicant

❑ Reinstatement

Employer/Plan Administrator - Complete this section

	Group Number	Effective Date (mm/dd/yy)
Dental	D__ __ __ __ __ __	
EHC	E__ __ __ __ __ __	
Other	❑ D ❑ E __ __ __ __ __ __	
BC Life	__ __ __ __ __ __	
ID Number (e.g., SIN) __ __ __ __ __ __ __ __ __		

Applicant - Complete this section

Surname	First name	Middle initial

Birthdate (mm/dd/yy)	Sex ❑ M ❑ F	Provincial Health Plan No. (e.g., Care Card)

Address	City	Province	Postal code

Dep. no.	Surname* (* not required if same as yours)	First name	Middle initial	Birthdate (mm/dd/yy)	Sex	Relationship to you
01	Spouse				❑ M ❑ F	
02	1st child				❑ M ❑ F	
03	2nd child				❑ M ❑ F	
04	3rd child				❑ M ❑ F	
05	4th child				❑ M ❑ F	

If child is over plan's age limit (e.g., 19 or 21) and attending school full-time, provide name of school. If child is disabled, state details of disability to apply for coverage beyond plan's age limits.

Dep. number ______ ❑ Name of school or ❑ details of disability ________________________________

Dep. number ______ ❑ Name of school or ❑ details of disability ________________________________

(Use reverse side for additional dependents) ❑ I have listed dependents on the reverse side

Were you covered within the last 6 months, or are you presently covered, under another group Dental or EHC plan? ❑ Yes ❑ No

If yes, provide:

Name of insurance company	Group/policy number	ID or certificate number

List benefits covered under other plan: ❑ EHC ❑ Dental ❑ Life & AD&D ❑ Critical Illness ❑ STD ❑ LTD

Is the plan still active? ❑ Yes ❑ No If no, state termination date (mm/dd/yy) ____________________

Beneficiary Designation

I designate as revocable beneficiary in the event of my death:

Full legal name	Relationship to you	Share of proceeds
		%
		%

Trustee Designation (Complete only if beneficiary is under age 18):

I appoint as revocable Trustee to receive from BC Life any amount which may be due to my beneficiary, while such beneficiary is a minor:

Full legal name

Employer/Plan Administrator - Complete this section

Name of company/organization	Applicant's occupation	Class code	Department code	Employee number

Date of full time hire mm/dd/yy (new applicant)	Date of rehire mm/dd/yy (reinstatement)	Applicant's earnings ❑ Hr ❑ Wk ❑ Bi-Wk ❑ Mo ❑ Yr $	Hours per week	Is waiver card attached? ❑ Yes ❑ No

If we have questions about this application, how can we contact you: ❑ phone ____________________ ❑ e-mail ____________________

I agree to the conditions of the contract between my plan sponsor and Pacific Blue Cross/BC Life and authorize my employer to deduct required contributions from my earnings. By providing my Social Insurance Number, I authorize Pacific Blue Cross/BC Life to use it for identification purposes only. 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/BC Life up to the amount advanced to me pending such settlement or judgement.

I understand and consent that some of the personal information provided by me and my dependents under this group plan may be disclosed to agents and representatives of Pacific Blue Cross/BC Life and other providers/insurers and their agents and representatives for the purposes of assessing and providing benefit coverage. I also understand and consent to the disclosure of this personal information to my employer when required or permitted by contract between Pacific Blue Cross/BC Life and my plan sponsor and to the retention, use and disclosure of this personal information in accordance with Pacific Blue Cross/BC Life's privacy policy.
A copy of the privacy policy is available by contacting Pacific Blue Cross/BC. It is also available at www. pac.bluecross.ca or from my plan sponsor.

I confirm that this applicant is eligible to apply for coverage.

X ______________________________
Signature of applicant Date

X ______________________________
Signature of employer/Plan administrator Date

PACIFIC BLUE CROSS™

BC Life®

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APPLICANT, please:

- Read these instructions carefully before you start writing. Ask your employer or plan administrator for help if necessary.
- List all your dependents (your spouse and children) whether or not you require coverage for them. If you have more than 4 children, please provide the required information below.
- You may waive Dental Care and Extended Health Care if you have similar coverage under another plan. Otherwise, these and other benefits may be waived if the group plan rules specifically allow you to do so. If you are waiving benefits, complete a waiver of group benefits form.
- If your plan includes Group Life or Accidental Death & Dismemberment insurance provided by BC Life, name at least one beneficiary (and trustee, if necessary); otherwise these benefits will be paid to your estate in the event of your death. If you make an error, sign or initial beside the correction.
- If you have a disabled child, provide complete details of the disability such as nature of the disability, date of onset and prognosis for recovery. His or her coverage will be continued beyond the normal age permitted under your plan if certain criteria are met.
- Sign and date the application and submit it to your employer or plan administrator as soon as possible. **Time limits may apply.**

EMPLOYER/PLAN ADMINISTRATOR, please:

- Use this form to add or reinstate applicants only. Use a change form to: transfer a member from one group to another; add or terminate dependents; and report changes.
- Indicate the group number(s) and ID number. Indicate the effective date for each benefit **only if** Pacific Blue Cross and/or BC Life has specifically instructed you to do so; otherwise leave the effective date fields blank. Ordinarily, Pacific Blue Cross/ BC Life will determine the effective date.
- The applicant's occupation (be specific), class code and earnings are required only if your plan includes BC Life Benefits.
- Date of hire means the date the applicant started working as an eligible employee as defined in your group contract/policy (not necessarily the first day of work). For example, if an employee was hired on June 1, 2004, on a casual basis working only 8 - 12 hours per week, and then on September 1, 2004, was hired on a permanent part-time basis working 20 hours per week and as such qualified for benefits under your plan, indicate September 1, 2004, as the date of hire.
- Include the department code and/or employee number if it is required by your plan, e.g., if your invoices or ID cards are sorted by one of these numbers.
- The applicant (and dependents) will be enrolled for all benefits, unless a waiver of group benefits form is submitted with this application.
- Ensure that the applicant has completed all relevant sections. Beneficiaries and trustee, where applicable, should be written in the applicant's own handwriting.
- Ensure that the application form is signed and dated by both the applicant and you.
- You may fax this to us at 604 419-2149. If you fax us this application, **do not** send us the original.

(**Note:** It may not always be possible for applicants to waive coverage.)

CARESnet™ provides Pacific Blue Cross members with secure online access to their personal health and dental benefit information. When you receive your ID card, visit www.pac.bluecross.ca to register for CARESnet™.

Additional dependent information (cont'd)

Dep. no.	Surname* (* not required if same as yours)	First name	Middle initial	Birthdate (mm/dd/yy)	Sex	Relationship to you
06	5th child				❑ M ❑ F	
07	6th child				❑ M ❑ F	
08	7th child				❑ M ❑ F	

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® BC Life is the registered trade-name of British Columbia Life & Casualty Company, a wholly–owned subsidiary of Pacific Blue Cross.

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