

INDIVIDUAL APPLICATION FOR GROUP BENEFITS

- Health & Dental Benefits Health Spending Account Benefits
 Wellness Spending Account Benefits

EMPLOYEE INFORMATION										
LAST NAME			FIRST NAME			INITIAL	BIRTH DATE			SEX
							DD	MM	YY	M/F
MAILING ADDRESS							PHONE #1			
							()			
CITY			PROVINCE		POSTAL CODE		PHONE #2			
							()			
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Legally Married <input type="checkbox"/> Common-Law										
If Common-Law, Complete Commencement Date of Co-habitation: DD MM YYYY										

DEPENDENT INFORMATION												
If more space is required, please attach a separate page listing all information below.												
		LAST NAME		FIRST NAME		INITIAL	BIRTH DATE			SEX	Dependent Status	
							DD	MM	YY	M/F	Student (College/University)	Disabled
SPOUSE	01											
CHILD	02											
CHILD	03											
CHILD	04											
CHILD	05											

WAIVER OF BENEFITS

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

I choose to: Waive ALL benefits Waive Only: _____

Reason: _____

COORDINATION OF BENEFITS

Do you or any of your dependents have alternate Health and/or Dental coverage? Yes No

If Yes, please complete the following:

		Health		Dental		Insurer		Policy #	
EMPLOYEE	COVERAGE	<input type="checkbox"/> Single	<input type="checkbox"/> Couple	<input type="checkbox"/> Family	<input type="checkbox"/> Single	<input type="checkbox"/> Couple	<input type="checkbox"/> Family	ID No	
								Coverage Effective Date	
DEPENDENT	COVERAGE	<input type="checkbox"/> Single	<input type="checkbox"/> Couple	<input type="checkbox"/> Family	<input type="checkbox"/> Single	<input type="checkbox"/> Couple	<input type="checkbox"/> Family	Cardholder Name	
								ID No	Coverage Effective Date

AUTHORIZATION AND CONSENT

I, the undersigned, declare that the answers to the above questions are complete and accurate and form part of an application for coverage with Saskatchewan Blue Cross and/or Blue Cross Life Insurance Company of Canada® (Blue Cross Life). The discovery of facts known by me or my eligible dependents but not stated in this application could result in the cancellation or modification of coverage or denial of a claim. All information provided herein and collected in the future as part of the application process will be used to determine eligibility for coverage and will be kept confidential and secure. I understand that any coverage which is subject to approval of medical evidence is not effective unless and until approved by Saskatchewan Blue Cross and/or Blue Cross Life. I understand that the personal information provided herein as well as any other personal information currently held or collected in the future by Saskatchewan Blue Cross and/or Blue Cross Life 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 develop and recommend suitable products and services to me and to manage the business of Saskatchewan Blue Cross and/or Blue Cross Life. Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These include other Blue Cross® organizations, licensed physicians and/or any other healthcare 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 my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, 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 the privacy policies of Blue Cross and/or the collection, use or disclosure of my personal information, I can visit sk.bluecross.ca or call 1-800-USEBLUE®.

I certify all of the above information is true and complete. I have read and agree to the Authorization and Consent.

Signature of Applicant _____ Signature of Witness _____ Date _____

TO BE COMPLETED BY EMPLOYER OR ADMINISTRATOR

					Permanent Date Employed				
Name of Employer				Occupation			DD	MM	YY
Payroll No.	Class	HSA Initial Bank Load \$ _____	WSA Initial Bank Load \$ _____	Completed for Employer by					
Policy & Section #	Hours Worked per Week _____	Signature _____			Date _____				

PLEASE RETAIN A COPY OF THIS APPLICATION FOR YOUR RECORDS

FOR SASKATCHEWAN BLUE CROSS USE ONLY			Effective Date				
ID No.	Policy and Section #		Cross Reference I.D. from		DD	MM	YY