

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

**i APPLICANTS — Please complete BLACK portions of this application.**  
**EMPLOYERS/PLAN ADMINISTRATORS — Please complete RED portions of this application.**  
 See page 3 for tips for completing this application.

New applicant  Reinstatement

## PART 1 — EMPLOYER/PLAN ADMINISTRATOR

Policy number	Dental effective date (mm-dd-yyyy)	Extended health effective date (mm-dd-yyyy)
BC Life effective date (mm-dd-yyyy)	Other effective date (mm-dd-yyyy)	ID number

## PART 2 — APPLICANT INFORMATION

First name	Last name	Middle initial	Birthdate (mm-dd-yyyy)	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Street address		City	Province	Postal code
Email address		Do you have a government health/medical plan in any province or territory? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Please provide the information requested in the table below.  
 List any additional children in *Part 8 — Additional Information*.

Does your spouse/child have a government health/medical plan in any province or territory?

FIRST NAME	LAST NAME	MIDDLE INITIAL	BIRTHDATE	SEX	RELATIONSHIP TO YOU	SCHOOL NAME + STUDENT NUMBER*
Spouse			(mm-dd-yyyy)	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Common-Law <input type="checkbox"/> Married	<input type="checkbox"/> Yes <input type="checkbox"/> No
First child			(mm-dd-yyyy)	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No
Second child			(mm-dd-yyyy)	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No
Third child			(mm-dd-yyyy)	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No
Fourth child			(mm-dd-yyyy)	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> 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* which is available online at [www.pac.bluecross.ca](http://www.pac.bluecross.ca).  
 Their coverage will be continued beyond the minor maximum age if certain criteria are met.

## PART 3 — BENEFICIARY DESIGNATION

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

Full legal name	Birthdate (mm-dd-yyyy)	Relationship to you	Share of proceeds %
Full legal name	Birthdate (mm-dd-yyyy)	Relationship to you	Share of proceeds %

### Trustee designation (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 the beneficiary is a minor:

Full legal name	Birthdate (mm-dd-yyyy)	Relationship to you
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For residents of the Province of Quebec, the designation of a spouse is irrevocable unless otherwise specified. 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.

## PART 4 — COORDINATION OF BENEFITS

If you or any of your dependents were covered under another plan within the last 6 months, please indicate the following:

Name of insurance company	Name of member with other insurance company	Group/policy number	Policy effective date (mm-dd-yyyy)	ID or certificate number
Employment type <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Retiree	Benefits covered under the other plan <input type="checkbox"/> EHC <input type="checkbox"/> Dental	Is the plan still active? <input type="checkbox"/> Yes <input type="checkbox"/> No — termination date (mm-dd-yyyy): _____		

## PART 5 — EMPLOYER/PLAN ADMINISTRATOR TO COMPLETE THIS SECTION

Name of company/organization		Division	Sub-division (if applicable)	Class	Section ID
Applicant's occupation		PBC office use: Occ. code	Employment type <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Retired <input type="checkbox"/> Hour bank <input type="checkbox"/> Other: _____		
Payroll number	Date of full-time hire (mm-dd-yyyy)	Date of rehire (mm-dd-yyyy)	Applicant's salary \$ _____	<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually	Hours per week

If we have questions, how can we contact you?  Telephone: \_\_\_\_\_  Email: \_\_\_\_\_

## PART 6 — EMPLOYEE AND EMPLOYER/PLAN ADMINISTRATOR SIGNATURES

I agree to the conditions of the contract between my employer/plan administrator and Pacific Blue Cross/BC Life 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/BC Life up to the amount advanced to me pending such settlement or judgement.

I consent to Pacific Blue Cross/BC Life collecting, using and disclosing my personal information where reasonably necessary for the purposes of my enrolment or coverage under this group plan. I consent to the disclosure of my personal information 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 benefits coverage. I also consent to the disclosure of my personal information to my employer/plan administrator when required or permitted by contract between Pacific Blue Cross/BC Life and my employer/plan administrator; and to the retention, use and disclosure of my personal information in accordance with the Pacific Blue Cross/BC Life privacy policy.

The privacy policy is available from your employer/plan administrator, online at [www.pac.bluecross.ca](http://www.pac.bluecross.ca) or by calling Pacific Blue Cross/BC Life at 604 419-2000.

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

## PART 7 — WAIVER OF GROUP BENEFITS: Complete this section if waiving benefits

The Pacific Blue Cross Extended Health Care (EHC) plan is not the same as coverage under a government health/medical plan in any province or territory. If another plan covers you/your dependent(s) for EHC or Dental benefits, you may waive such benefits under this plan. Before you sign this form, read your employee booklet or ask your employer to explain the benefits to you. You should fully understand all the benefits and plan rules.

### SECTION A — Waiver certified by employer

I do not want coverage for the following:  Extended Health Care  Dental Care  For myself and my dependents  Dependents only

I do not want coverage for the following BC Life benefits:  Group term life  Accidental death & dismemberment  Short-term disability  
 Long-term disability  Dependent life  Critical illness

**EMPLOYER/PLAN ADMINISTRATOR — I hereby certify that: minimum participation requirements, as stipulated in the contract, have been met; this plan requires members/employers to contribute to the cost of coverage; benefit coverage is not a condition of employment.**

Employer/Plan administrator's signature <b>X</b>	Date (mm-dd-yyyy)
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### SECTION B — Waiver due to coverage under another plan

I choose to waive the benefit(s) below because I am covered by another plan (named in *Part 4 — Coordination of Benefits*):

Extended Health Care  Dental care  For myself and my dependents  Dependents only

If the other plan terminates, I understand that there may be time limits for applying for coverage under this Pacific Blue Cross plan. If I apply late, or if I apply while the other plan is still active, I understand that dental coverage may be restricted to \$250 per person for the first year, and/or my dependents and I will have to provide evidence of good health, and Pacific Blue Cross may decline to cover me or my dependents.

### Employee signature is required for SECTIONS A and B

I have been offered the opportunity to participate in my employer's benefits plan under the policy number(s) on page 1. I have carefully studied the benefits and the plan rules, and I understand that if I apply at a later date for any benefit(s) that I am now waiving, as explained above, dental coverage may be restricted to \$250 per person for the first year of coverage, and/or I will be required to prove, at my own expense, that I and my dependents are in good health. Pacific Blue Cross and/or BC Life reserve the right to refuse my application if my health or my dependents' health is not considered satisfactory.

Employee's signature <b>X</b>	Date (mm-dd-yyyy)
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## PART 8 — ADDITIONAL INFORMATION

## TIPS FOR COMPLETING THIS APPLICATION

1. List all your dependents (your spouse and children) even if they are waiving coverage.
2. You may waive Dental Care and Extended Health Care coverage 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 *Part 7 — Waiver of Group Benefits*.
3. Time limits may apply. Sign and date the application and submit it to your employer or Plan administrator as soon as possible.

**! INCOMPLETE INFORMATION MAY DELAY THE PROCESSING OF YOUR APPLICATION.**



### **MAIL YOUR APPLICATION**

Pacific Blue Cross  
PO Box 7000, Vancouver, BC V6B 4E1



### **DROP IT OFF**

4250 Canada Way  
Burnaby, BC V5G 4W6



### **FAX IT**

604 419-2149



### **EMAIL IT**

enrollment@pac.bluecross.ca

[www.pac.bluecross.ca](http://www.pac.bluecross.ca)