MANITOBA BLUE CROSS®

PO BOX 1046 STN MAIN WINNIPEG MB R3C 2X7
TEL 204.775.0151 Fax 204.772.1231

# CITY OF WINNIPEG RETIREE GROUP BENEFITS PLAN APPLICATION

**THIS SECTION TO BE COMPLETED BY RETIREE**
**RETIREES MUST APPLY WITHIN 60 DAYS OF RETIREMENT**

| LAST NAME | FIRST NAME | DATE OF BIRTH (DD MM YYYY) | |
|---|---|---|---|
| MAILING ADDRESS - STREET/BOX NUMBER | CITY OR TOWN | PROVINCE | POSTAL CODE |
| PHONE NUMBER | GENDER ☐ MALE ☐ FEMALE | PROVINCIAL HEALTH NUMBER? YES ☐ NO ☐ | DATE RETIRED (DD/MM/YYYY) | EMAIL ADDRESS |

**PLEASE COMPLETE THIS SECTION IF YOU HAVE ELIGIBLE DEPENDENTS**

| ☐ SPOUSE ☐ COMMON LAW | LAST NAME (if different than retiree) | FIRST NAME | DATE OF BIRTH DD MM YYYY | GENDER ☐ MALE ☐ FEMALE |
|---|---|---|---|---|

**IF APPLICANT AND SPOUSE ARE NOT LEGALLY MARRIED PLEASE PROVIDE COMMENCEMENT DATE OF COHABITATION (DD/MM/YYYY)**_____

UNMARRIED DEPENDENT CHILDREN:

| LAST NAME (if different than retiree) | FIRST NAME | RELATIONSHIP | DATE OF BIRTH DD | MM | YYYY | GENDER |
|---|---|---|---|---|---|---|
| | | | | | | ☐ MALE ☐ FEMALE |
| | | | | | | ☐ MALE ☐ FEMALE |
| | | | | | | ☐ MALE ☐ FEMALE |
| | | | | | | ☐ MALE ☐ FEMALE |
| | | | | | | ☐ MALE ☐ FEMALE |
| | | | | | | ☐ MALE ☐ FEMALE |

COVERAGE APPLIED FOR:

**CHECK (✓) WHICH OPTION YOU ARE SELECTING**

- ☐ 1. AMBULANCE/ HOSPITAL
- ☐ 2. AMBULANCE/HOSPITAL & EXTENDED HEALTH (no Travel Health)
- ☐ 3. AMBULANCE/HOSPITAL, EXTENDED HEALTH & TRAVEL HEALTH
- ☐ 4. AMBULANCE/HOSPITAL, EXTENDED HEALTH & DENTAL (no Travel Health)
- ☐ 5. AMBULANCE/HOSPITAL, EXTENDED HEALTH, DENTAL & TRAVEL HEALTH

- **RETIREE MUST ENROLL ACCORDING TO TRUE FAMILY STATUS WITHIN 60 DAYS OF RETIREMENT.**
- **IN ORDER TO PROTECT THE VIABILITY OF THESE PLANS, MEMBERS ENROLLED IN SUPPLEMENTARY HEALTH PLANS ARE NOT PERMITTED TO OPT-OUT OTHER THAN AS DESCRIBED IN THE PLAN RULES.**

DO YOU OR YOUR DEPENDENTS HAVE COVERAGE FOR ANY OF THE BENEFITS APPLIED FOR THROUGH ANOTHER INSURANCE PLAN? ❑ YES ❑ NO - IF YES, PLEASE INDICATE

| BENEFITS COVERED | NAME OF INSURED | NAME OF INSURANCE COMPANY |
|---|---|---|
| ☐ HEALTH ☐ DENTAL ☐ HSA ☐ VISION ☐ DRUGS ☐ HOSPITAL ☐ AMBULANCE | | |

☐ I certify the above information is true and correct, that all participants are eligible for coverage per the group agreement. I understand that it is my responsibility to notify Manitoba Blue Cross immediately if a participant no longer meets the criteria to remain on my plan. At Retirement, I may chose to participate in the Retiree Healthcare & Dental Plans provided by Manitoba Blue Cross. I have read and understood the Authorization & Consent on the reverse side of this form and agree to the conditions of the group agreement between my employer and Manitoba Blue Cross.

RETIREE SIGNATURE _____ DATE _____

**HOW TO SUBMIT THIS FORM**

| **Mail:** | **In Person:** | **Fax:** | **Email:** |
|---|---|---|---|
| Attention: Client Services<br>PO Box 1046 Stn Main<br>Winnipeg, MB R3C 2X7 | 599 Empress Street, Winnipeg, Manitoba | Attention: Client Services<br>204.774.1761 | MBCgroupbenefits@mb.bluecross.ca |

**BLUE CROSS USE ONLY**

| GROUP NUMBER | ROLL | COVERAGE EFFECTIVE (DD/MM/YYYY) | CERTIFICATE NUMBER |
|---|---|---|---|
| | | | |

## 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.

## CITY OF WINNIPEG RETIREE AUTHORIZATION AND CONSENT

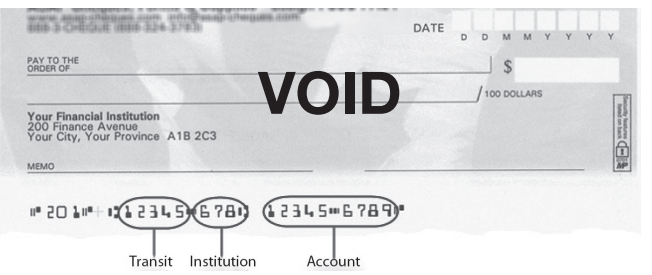
By providing my signature directly below this paragraph, I further consent to the City of Winnipeg's benefit consultant HUB International collecting and using my contact information including my email address for the purpose of providing me with periodic newsletters, updates and/or information integral to the group policy of which I am a member. I also consent to HUB International to share my information to the City of Winnipeg for the purpose of providing me with periodic newsletters, updates and/or information integral to the group policy of which I am a member.

Authorized Signature _____ Date _____

| PRE-AUTHORIZED DEBIT APPLICATION | | |
|---|---|---|
| FIRST NAME | LAST NAME | |
| ADDRESS | | |
| CITY | PROVINCE | POSTAL CODE |
| EMAIL ADDRESS | | |
| PHONE NUMBER (home) | PHONE NUMBER (cell) | |

| FINACIAL INSTITUTION'S INFORMATION | | |
|---|---|---|
| FINANCIAL INSTITUTION NAME | | |
| TRANSIT NUMBER | INSTITUTION NUMBER | ACCOUNT NUMBER |

**For verification purposes, please enclose a void cheque**




I authorize Manitoba Blue Cross to perform a personal Pre-Authorized Debit (PAD) on the first business day of each billing period. The amount may vary. I will notify Manitoba Blue Cross in writing of any changes to my account information. I may revoke my authorization at any time, subject to providing notice of 30 days. For more information on my right to cancel a PAD agreement, I may contact my finiancial institution or visit www.cdnpay.ca. I have certain resource rights if any debit does not comply with this agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit wwww.cdnpay.ca.

I authorize Manitoba Blue Cross to transfer ALL claim payments to the Financial Institution indicated above. Please include all signatures required for cheque endorsement.

Authorized Signature _____ Date _____

Second Authorized Signature _____ Date _____