MANITOBA BLUE CROSS®

CITY OF WINNIPEG
RETIREE GROUP BENEFITS PLAN
NOTICE OF CHANGE FORM

CERTIFICATE NUMBER _____

RETIREE NAME _____

CLIENT NUMBER 66000

EMAIL ADDRESS _____

RETIREE: Please complete the appropriate section(s) and return to Manitoba Blue Cross.

1- CHANGE OF MAILING OR EMAIL ADDRESS

EFFECTIVE DATE _____ dd/mm/yyyy

EMAIL ADDRESS _____

MAILING ADDRESS - STREET/BOX NUMBER _____

CITY, TOWN AND PROVINCE _____ POSTAL CODE _____

2 - TERMINATE COVERAGE

If terminating coverage, proof of alternate coverage is required within 60 days. Cancellation Request form is available on the Retiree Portal: www.hubinternational.com/citywpgretiree.

DATE OF TERMINATION _____ dd/mm/yyyy

REASON _____

3 - CHANGE OF NAME (if due to marriage, section 4 must be completed)

FROM _____
NAME IN FULL

TO _____
NAME IN FULL

4 - ADDITION OF SPOUSE AND/OR DEPENDENT

NAME IN FULL _____

RELATIONSHIP TO RETIREE: (Please check)

☐ LEGAL SPOUSE ☐ COMMON-LAW SPOUSE ☐ CHILD ☐ COMMON-LAW CHILD

☐ OTHER _____

GENDER ☐ Male ☐ Female DATE OF BIRTH _____ dd/mm/yyyy

DATE OF MARRIAGE/ COHABITATION _____ dd/mm/yyyy

5 - DELETION OF SPOUSE AND/OR DEPENDENT (S)

NAME IN FULL _____

REASON _____ DATE _____ dd/mm/yyyy

6 - CHANGE COVERAGE

If adding coverage, proof of loss is required. If cancelling coverage, proof of alternate coverage is required. Proof of loss or alternate coverage is required within 60 days. Loss of Coverage form and Cancellation Request form are available on the Retiree Portal: www.hubinternational.com/citywpgretiree.

☐ 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

Reason for change _____

7 - CO-ORDINATION OF BENEFITS

☐ I AND / OR MY DEPENDENTS HAVE COVERAGE THROUGH ANOTHER INSURANCE PLAN

☐ I AND / OR MY DEPENDENTS LOST COVERAGE THROUGH ANOTHER INSURANCE PLAN

CANCELLATION DATE _____
dd/mm/yyyy

BENEFITS COVERED (PLEASE COMPLETE FOR EITHER CHECKED ABOVE)

☐ AMBULANCE ☐ DENTAL ☐ VIRTUAL CARE ☐ PRESCRIPTION DRUGS

☐ VISION ☐ EXTENDED HEALTH ☐ HSA ☐ HOSPITAL ☐ TRAVEL

NAME OF INSURED _____

NAME OF INSURANCE COMPANY _____

8 - OTHER CHANGES (SPECIFY)

_____

_____

_____

I CERTIFY THE ABOVE INFORMATION IS TRUE AND CORRECT AND THAT ALL PARTICIPANTS ARE ELIGIBLE FOR COVERAGE AS PER THE GROUP AGREEMENT. I UNDERSTAND IT IS MY RESPONSIBILITY TO NOTIFY MANITOBA BLUE CROSS IMMEDIATELY IF A PARTICIPANT NO LONGER MEETS THE CRITERIA TO REMAIN ON MY PLAN. I HAVE READ AND UNDERSTAND THE AUTHORIZATION & CONSENT AND AGREE TO THE CONDITIONS OF THE GROUP AGREEMENT BETWEEN MY EMPLOYER AND MANITOBA BLUE CROSS.

RETIREE SIGNATURE _____ DATE _____
dd/mm/yyyy

AUTHORIZATION & 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 Manitoba 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 Manitoba Blue Cross or one of its authorized service providers.

I understand that I have provided my consent for Manitoba Blue Cross to collect, use and disclose my personal information as outlined in the Manitoba 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 or for questions as to the collection, use or disclosure of my personal information, I can contact Manitoba Blue Cross at 204.775.0151 or 1.800.873.2583 or mb.bluecross.ca.

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 _____
dd/mm/yyyy

HOW TO SUBMIT THIS FORM

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