



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



CITY OF WINNIPEG

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

RETIREE GROUP BENEFITS PLAN APPLICATION

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			GENDER
			DD	MM	YYYY	☐ 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			GENDER ☐ MALE ☐ FEMALE
			DD	MM	YYYY	
						☐ 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 ☐ HEALTH ☐ DENTAL ☐ HSA ☐ VISION ☐ DRUGS ☐ HOSPITAL ☐ AMBULANCE	NAME OF INSURED	NAME OF INSURANCE COMPANY
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☐ 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: Attention: Client Services PO Box 1046 Stn Main Winnipeg, MB R3C 2X7	In Person: 599 Empress Street, Winnipeg, Manitoba	Fax: Attention: Client Services 204.774.1761	Email: MBCgroupbenefits@mb.bluecross.ca
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BLUE CROSS USE ONLY

GROUP NUMBER	ROLL	COVERAGE EFFECTIVE (DD/MM/YYYY)	CERTIFICATE NUMBER
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AUTHORIZATION AND CONSENT

I understand that the personal information and personal health information provided herein as well as any other personal information and personal health information currently held or collected in the future by Manitoba Blue Cross and/or the Blue Cross Life Insurance Company of Canada (collectively referred to as 'Blue Cross') may be collected, used, or disclosed to administer the terms of the policy (including the determination of eligibility for insurance coverage, benefits and services and for processing and settling claims) 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 or personal health 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 the 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 or personal health 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 or personal health 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 and personal health information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding Blue Cross's privacy policies or for questions as to the collection, use or disclosure of my personal information, I can contact Blue Cross at 204.775.0151 or 1.800.873.2583 or visit mb.bluecross.ca.

I authorize Blue Cross to collect, use and disclose my personal information and personal health information as described above.

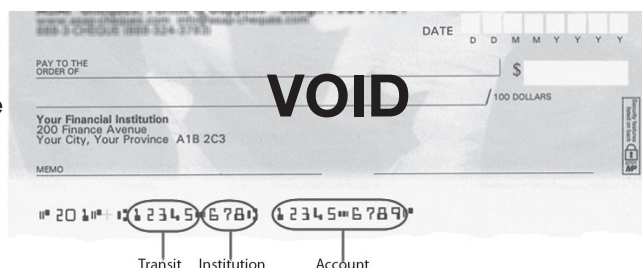
CITY OF WINNIPEG RETIREE AUTHORIZATION AND CONSENT

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)
FINANCIAL 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 financial 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 www.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 _____