MANITOBA BLUE CROSS®

PO BOX 1046 STN MAIN WINNIPEG MB R3C 2X7
TEL 204.775.0151 Fax 204.774.1761

Winnipeg

CITY OF WINNIPEG
RETIREE GROUP BENEFITS PLAN
LOSS OF SPOUSAL/ALTERNATE GROUP COVERAGE FORM

RETIREE NAME	CERTIFICATE NUMBER	CLIENT NUMBER
		66000

This portion is to be completed by employer or alternate group insurance provider

This is to advise that _____ had coverage
name

through _____ .
name of insurance company

This coverage was for: Type of coverage: ☐ Extended Health ☐ Ambulance/ Hospital at a _____ status
single/family

☐ Travel ☐ Dental

These benefits were effective as of _____.
date (dd/mm/yyyy)

These benefits were cancelled as of _____.
date (dd/mm/yyyy)

Employer/Alternate Insurer Name: _____

Employer/Alternate Insurer Signature: _____

Phone Number: _____

Must be returned within 60 days of loss of other coverage

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

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.

2026-0630

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