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
RE-ENROLLMENT CHANGE FORM

COMPLETION OF THIS FORM IS ONLY REQUIRED IF YOU ARE MAKING A CHANGE

COMPLETED FORM MUST BE RECEIVED BY MANITOBA BLUE CROSS BY **JUNE 10, 2026**

LATE APPLICATIONS WILL NOT BE ACCEPTED

THIS SECTION TO BE COMPLETED BY RETIREE

LAST NAME	FIRST NAME	CERTIFICATE NUMBER

ADDRESS	FAMILY STATUS
	☐ SINGLE ☐ COUPLE ☐ FAMILY
CURRENT COVERAGE OPTION	EMAIL ADDRESS - Please provide

If you need to change your contact or dependent information (including existing coverage through a spouse), please complete/submit the Notice of Change form available on the Retiree Portal: www.hubinternational.com/citywpgretiree.

THIS IS AN OPPORTUNITY TO CHANGE YOUR COVERAGE. COVERAGE CHANGE WILL BE EFFECTIVE JULY 1, 2026.

IF YOU ARE MAKING A CHANGE AND ARE CURRENTLY PAYING MONTHLY PREMIUMS THROUGH PENSION DEDUCTION, YOU ARE REQUIRED TO SET-UP PRE-AUTHORIZED DEBIT BEFORE THE CHANGE CAN TAKE EFFECT. PLEASE COMPLETE THE PRE-AUTHORIZED DEBIT APPLICATION AT THE BACK OF THIS FORM.

ONCE ENROLLED, COVERAGE CANNOT BE CHANGED UNTIL THE NEXT RE-ENROLLMENT ON JULY 1, 2028 OR UNLESS YOU EXPERIENCE A LIFE EVENT (see Frequently Asked Questions on Portal: www.hubinternational.com/citywpgretiree).

Check ☑ WHICH OPTION YOU ARE SELECTING

- ☐ OPTION 1 - AMBULANCE / HOSPITAL
- ☐ OPTION 2 - AMBULANCE / HOSPITAL & EXTENDED HEALTH (no Travel Health)
- ☐ OPTION 3 - AMBULANCE / HOSPITAL, EXTENDED HEALTH & TRAVEL HEALTH
- ☐ OPTION 4 - AMBULANCE / HOSPITAL, EXTENDED HEALTH & DENTAL (no Travel Health)
- ☐ OPTION 5 - AMBULANCE / HOSPITAL, EXTENDED HEALTH, DENTAL & TRAVEL HEALTH
- ☐ OPT OUT OF ALL COVERAGE (You can only re-join the plan within 60 days of an eligible life event. Please visit the FAQs on the Retiree Portal for important plan rules surrounding opting out of coverage).

☐ I certify the above information is true and correct and agree to the conditions of the group agreement. 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 Manitoba Blue Cross and the City of Winnipeg.

RETIREE SIGNATURE _____ DATE _____

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	openenrollment@mb.bluecross.ca

BLUE CROSS USE ONLY

GROUP NUMBER	ROLL	COVERAGE EFFECTIVE (DD/MM/YYYY)	CERTIFICATE NUMBER
		July 1, 2026	

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 _____

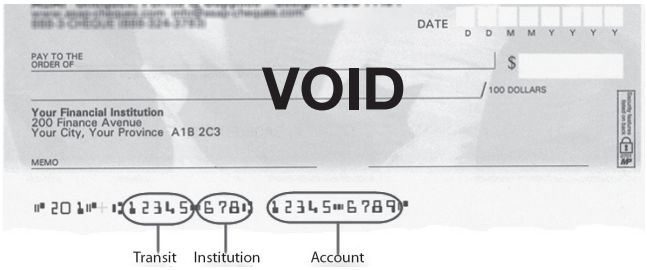
PRE-AUTHORIZED DEBIT APPLICATION

FIRST NAME	LAST NAME	
ADDRESS		
CITY	PROVINCE	POSTAL CODE
EMAIL ADDRESS		
PHONE NUMBER (home)	PHONE NUMBER (cell)	

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 business Pre-Authorized Debit (PAD) on the designated date of every month for each billing period. The amount may vary. I will notify Manitoba Blue Cross in writing or by email of any changes to my account information or if I would like to cancel my PAD agreement. Upon receiving my request, any changes will require five business days to take effect. 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.payments.ca. **I have certain recourse 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.payments.ca.**

I understand that my personal information will be kept confidential and secure.

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 may contact Manitoba Blue Cross at mbcprivacyofficer@mb.bluecross.ca or 1.800.873.2583.

I can access Manitoba Blue Cross's privacy code at mb.bluecross.ca/legal/privacy-policy.

Authorized Signature _____ Date _____

Second Authorized Signature _____ Date _____