MEDAVIE BLUE CROSS™
PO BOX 2000, 185 THE WEST MALL, SUITE 1200
ETOBICOKE ON M9C 5P1
TEL: 1-855-811-0020
CO@medavie.ca

GROUP BENEFITS APPLICATION

1. TO BE COMPLETED BY THE EMPLOYER

Name of Employer: Brant Community Healthcare System (BCHS)

Policy Number: 99214 Division Number: _____ Class: _____

Permanent Date Employed (DD/MM/YYYY): _____ Eligible Date of Coverage (DD/MM/YYY): _____

Occupation/Job Title: _____ Employee ID: _____

Number of hours worked per week: Regular Full-Time HCSA Allocation $ (if applicable): _____

Employer Signature: _____ Date (DD/MM/YYYY): _____

2. EMPLOYEE AND FAMILY INFORMATION

Employee First Name: _____ Employee Last Name: _____

Sex*: ○Male ○Female ○Intersex ○Undisclosed Language Preferred: ○ English ○ French

Date of Birth (DD/MM/YYYY): _____

Address (Street & Number): _____

City/Town: _____ Province: _____ Postal Code: _____

Telephone Number: _____ Employee E-mail Address: _____

Are all members of your immediate family eligible and enrolled with your provincial health plan such as OHIP,MSI, Pharmacare, Medicare etc.? ○ Yes ○No

Extended Health (EHC) Coverage:	**Semi-Private Hospital Coverage:**	**Dental Coverage:**
○Single ○Family	○Single ○Family	○Single ○Family

Spouse (if applicable)

First Name: _____ Last Name: _____

Sex*: ○ Male ○ Female ○ Intersex ○ Undisclosed Status: ○ Married ○ Common-Law Date of Birth (DD/MM/YYYY): _____

Date of co-habitation if common-law (DD/MM/YYYY): _____

*** Sex: Male/Female/Intersex/Undisclosed – Why do we ask? Some health conditions are more likely to occur based on sex. As a result, sex is used to assess your coverage. We recognize that your sex may differ from your gender identity.**

Dependent Children (if applicable)

First Name	Last Name	Date of Birth (DD/MM/YYYY)	Sex M/F/I/U	Dependent Status
			○M ○F ○I ○U	○ Disabled ○ Student - College/University
			○M ○F ○I ○U	○ Disabled ○ Student - College/University
			○M ○F ○I ○U	○ Disabled ○ Student - College/University
			○M ○F ○I ○U	○ Disabled ○ Student - College/University

OTHER COVERAGE (CO-ORDINATION OF BENEFITS)

Do you or any of your dependents have coverage under any other Plan? ○ Yes ○ No **If Yes, complete the following:**

Name of the Other Insurer: _____ Effective Date of Coverage (DD/MM/YYYY): _____

Policy Number: _____ ID Number: _____

Type of Coverage:	**Hospital**	**Vision**	**EHB**	**Drugs**	**Dental**	**All**
Single	☐	☐	☐	☐	☐	☐
Family	☐	☐	☐	☐	☐	☐

Name of Employer: _____

MEDAVIE BLUE CROSS™

PO BOX 2000, 185 THE WEST MALL, SUITE 1200
ETOBICOKE ON M9C 5P1
TEL: 1-855-811-0020
CO@medavie.ca

3. WAIVER OF COVERAGE

All benefits under your group insurance plan are optional for full-time and not eligible for part-time employees and are provided to you based on the group contract. However, you may waive the health and dental benefits if you have similar coverage under your spouse/common-law spouse's plan.

☐ I have been given the opportunity to apply for coverage but do not wish to participate. I understand that I will not be able to enrol in these plans at a later date without the mutual consent of my employer and Medavie Blue Cross. Also, I may be required to submit medical evidence of insurability at that time.

☐ I understand that should I lose spousal coverage, and do not apply for coverage under this policy within 31 days of losing spouse/common-law spouse's plan, I may be required to submit medical evidence of insurability to apply for coverage under this policy after the afore mentionned period of 31 days.

I do not want to participate in the following coverage: ○ Health ○ Dental ○ Both Health and Dental

For Quebec Residents: Participation in the Health coverage plan can only be declined due to spousal coverage. If declining the Health coverage, please complete your spouse's coverage information.

4. PRIVACY CONSENT

I understand that the personal information I have provided herein is collected and used by Medavie Blue Cross to administer the terms of my policy or the group policy of which I am an eligible member, recommend suitable products and services that I am eligible for as a member of a policy, and other applicable purposes, as described in the Medavie Blue Cross Privacy Statement at medaviebc.ca.

Depending on the type of coverage I carry, limited personal information such as claim, health and/or financial related data may be collected from and/or released to following third parties as required for the purposes of administering and managing the benefits outlined in the policy of which I am an eligible member. These third parties may include healthcare providers, other insurance companies, regulatory authorities and investigative bodies, services providers, and/or the cardholder of any contract under which I am a participant.

Where allowed by law, my information may be shared with Medavie Blue Cross employees or service providers in jurisdictions other than where it was collected. If I am a resident of Quebec, this includes transferring or disclosing my personal information to Medavie Blue Cross employees or service providers outside of that province.

I understand that my consent is only valid for the time it is needed to achieve the purposes outlined herein, unless I withdraw it. I understand I may withdraw my consent at any time. However, in some instances doing so may prevent Medavie Blue Cross from providing me with certain products or services that may be useful to me and/or my dependents. This consent complies with federal and provincial privacy laws.

For more details about our information practices, including how your personal information is protected, how to access or correct personal information, or if you have concerns or questions, please see our Medavie Blue Cross Privacy Statement available at medaviebc.ca or call 1-800-667-4511.

5. AUTHORIZATION

I certify that the information above is accurate and authorize payroll deductions, if required. I authorize Medavie Blue Cross and/or Blue Cross Life to collect, use and disclose my personal information as described in the Privacy Consent section above.

Employee Name (please print): _____

Employee Signature: _____ Date (DD/MM/YYYY): _____

6. PRESCRIPTION DRUG INSURANCE (QUEBEC ACT)

All persons under 65 years of age who have access to a group insurance plan must enrol in the plan unless they already participate in another group plan or have insurance under a spouse's group plan. Proof of coverage must be kept on file with the employer.

By enrolling in your employer's group insurance plan, you are required to also arrange for coverage for all eligible dependents unless they are already covered under another group insurance plan.

Your dependents do not qualify for coverage under the RAMQ's basic prescription drug insurance plan if you already have coverage under an employer's group plan with the exception of a spouse aged 65 years or over.

When you complete your income tax return, you will be asked to confirm that you have complied with the provisions of the Act.