PACIFIC BLUE CROSS®

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BRANCH Local 244 SEIU Local 2 Stronger Together BCGPWU

ENROLLMENT APPLICATION FOR GROUP BENEFITS

Mail: PO Box 24715, Stn F, Vancouver, BC V5N 5T8 | Drop it off: 4250 Canada Way, Burnaby, BC | admn@pac.bluecross.ca

MEMBER — Please complete Parts 2 to 6 of this application.
EMPLOYERS/PLAN ADMINISTRATORS — Please complete Part 1 of this application.
Please complete form electronically or print clearly in **INK**. Sign, date and submit your application to your Employer or Plan Administrator as soon as possible.

☐ New member ☐ Reinstatement

PART 1 — EMPLOYER/PLAN ADMINISTRATOR

Policy number	Name of company/organization	Member ID number	Social Insurance Number (SIN)
903244 Group 1			

Coverage effective date (mm-dd-yyyy)

Division	Sub-division (if applicable)	Class	Section ID (if applicable)	Plan Code (if applicable)

Member's occupation	Employment type
	☐ Full-time ☐ Part-time ☐ Retired ☐ Hour bank ☐ Other: _____

Date of full-time hire or rehire (mm-dd-yyyy)	Member salary	Hours per week
	$ _____ ☐ Hourly ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually	

PART 2 — MEMBER/DEPENDENT INFORMATION

Legal first name	Preferred name	Middle initial	Last name	Birthdate (mm-dd-yyyy)	Gender
					☐ M ☐ F

Street address	City	Province	Postal code

Email address	Phone number

Please provide the information requested in the table below. List any additional children in *Part 3 – Additional Information* section.
Please list all your dependents even if you are waiving coverage.

LEGAL FIRST NAME	PREFERRED NAME	MIDDLE INITIAL	LAST NAME	BIRTHDATE (MM-DD-YYYY)	GENDER	RELATIONSHIP TO YOU	FULL TIME STUDENT*	DISABLED DEPENDENT**
Spouse					☐ M ☐ F	☐ Common-Law ☐ Married		
First child					☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No
Second child					☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No
Third child					☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No
Fourth child					☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No

*Complete this section if child is over the maximum age as stated in your Group Benefit Contract and attending school full-time.
**If you have a child with a disability, provide a copy of the notice of approval decision from CRA in response to your disability tax credit certificate application.

PART 3 — ADDITIONAL INFORMATION

PART 4 — CO-ORDINATION OF BENEFITS

If you or any of your dependents have coverage under another plan, please indicate the following:

Name of Insurance company	Group Policy Number	ID or certificate number

See other side

PART 5 — BENEFICIARY DESIGNATION

If your plan includes Group Life or Accidental Death & Dismemberment insurance, designate at least one beneficiary. If you do not nominate a beneficiary, these benefits will be paid to your estate in the event of your death. If you make an error, sign or initial beside the correction. For residents of the Province of Quebec, the designation of a spouse is irrevocable unless otherwise specified. If share of proceeds for multiple beneficiaries is not indicated, the share will be split evenly between the listed beneficiaries.

☐ Revocable ☐ Irrevocable	I designate the following person(s) to receive any amount due under the group policy upon my death.		
Full legal name	Birthdate (mm-dd-yyyy)	Relationship to you	Share of proceeds %
Full legal name	Birthdate (mm-dd-yyyy)	Relationship to you	Share of proceeds %

Member trustee designation — Complete only if a beneficiary is under age 18

I hereby appoint as trustee to receive from British Columbia Life & Casualty Company any amount which may be due to my beneficiary, while the beneficiary is a minor:

Full legal name	Birthdate (mm-dd-yyyy)	Relationship to you

To appoint a contingent beneficiary(ies) in the event that your primary beneficiary(ies) die before you, complete our Beneficiary Designation Form.

PART 6 — MEMBER SIGNATURE AND UNION AUTHORIZATION

I agree to the conditions of my benefit plan between my employer/plan administrator and Pacific Blue Cross and authorize my employer to deduct the required contributions from my earnings. I confirm that the information I have provided is true and complete.

If I should receive a settlement or a judgement against a liable third party for wage loss or benefits covered under my group plan, I agree to and authorize the third party to reimburse Pacific Blue Cross up to the amount advanced to me pending such settlement or judgement.

I consent to Pacific Blue Cross collecting, using and disclosing my personal information where reasonably necessary for the purposes of my enrollment or coverage under this group plan. I consent to the disclosure of my personal information to agents and representatives of Pacific Blue Cross and other providers/insurers and their agents and representatives for the purposes of assessing and providing benefits coverage. I also consent to the disclosure of my personal information to my employer/plan administrator when required or permitted by law or by contract between Pacific Blue Cross and my employer/plan administrator; and to the retention, use and disclosure of my personal information in accordance with the Pacific Blue Cross privacy policy.

The privacy policy is available online at pac.bluecross.ca or by calling Pacific Blue Cross at 604 419-2000.

Member's signature X		Date (mm-dd-yyyy)
Union authorized signature X	Union stamp	Date (mm-dd-yyyy)