PACIFIC BLUE CROSS™ BC Life®

DO NOT WRITE IN THIS SPACE

APPLICATION FOR GROUP BENEFITS

Please return completed form to:
Human Resources, Strand Hall, Room 2170
Simon Fraser University
8888 University Drive, Burnaby, BC V5A 1S6

☐ New applicant ☐ Reinstatement

PART 1 — EMPLOYER/PLAN ADMINISTRATOR

Policy number	Dental effective date (mm-dd-yyyy)	Extended health effective date (mm-dd-yyyy)
902505		
BC Life effective date (mm-dd-yyyy)	**Other effective date (mm-dd-yyyy)**	**ID number**

PART 2 — APPLICANT INFORMATION

First name	Last name	Middle initial	Birthdate (mm-dd-yyyy)	Sex ☐ M ☐ F

Street address	City	Province	Postal code

Email address

Do you have a government health/medical plan in any province or territory? ☐ Yes ☐ No

Please provide the information requested in the table below.
List any additional children in *Part 8 — Additional Information*.

Does your spouse/child have a government health/medical plan in any province or territory?

FIRST NAME	LAST NAME	MIDDLE INITIAL	BIRTHDATE	SEX	RELATIONSHIP TO YOU		SCHOOL NAME + STUDENT NUMBER*
Spouse			(mm-dd-yyyy)	☐ M ☐ F	☐ Common-Law ☐ Married	☐ Yes ☐ No	
First child			(mm-dd-yyyy)	☐ M ☐ F		☐ Yes ☐ No	
Second child			(mm-dd-yyyy)	☐ M ☐ F		☐ Yes ☐ No	
Third child			(mm-dd-yyyy)	☐ M ☐ F		☐ Yes ☐ No	
Fourth child			(mm-dd-yyyy)	☐ M ☐ F		☐ 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, include a *Disabled Dependent Application Form* which is available online at www.pac.bluecross.ca.
Their coverage will be continued beyond the minor maximum age if certain criteria are met.

PART 3 — BENEFICIARY DESIGNATION

I designate as revocable beneficiary in the event of 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 %

Trustee designation (if beneficiary is under age 18)
I appoint as revocable Trustee to receive from BC Life 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

For residents of the Province of Quebec, the designation of a spouse is irrevocable unless otherwise specified. If your plan includes Group life or Accidental death & dismemberment insurance provided by BC Life, name at least one beneficiary (and trustee, if necessary); otherwise 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.

PART 4 — COORDINATION OF BENEFITS

If you or any of your dependents were covered under another plan within the last 6 months, please indicate the following:

Name of insurance company	Name of member with other insurance company	Group/policy number	Policy effective date (mm-dd-yyyy)	ID or certificate number

Employment type	Benefits covered under the other plan	Is the plan still active?
☐ Full-time ☐ Part-time ☐ Retiree	☐ EHC ☐ Dental	☐ Yes ☐ No — termination date (mm-dd-yyyy): _____

™® Pacific Blue Cross, the registered trade-name of PBC Health Benefits Society, is an independent licensee of the Canadian Association of Blue Cross Plans. BC Life is the registered trade-name of British Columbia Life & Casualty Company, a wholly-owned subsidiary of Pacific Blue Cross. CARESnet is the registered trade-mark of the Canadian Association of Blue Cross Plans, an association of independent Blue Cross Plans, and is used under license to Pacific Blue Cross. My Good Health is a trade-mark owned by Pacific Blue Cross. Only Pacific Blue Cross/BC Life can change the information in this document. Any other modification is strictly prohibited. 0451.001—30-20-200 03/14 CUPE 1816

PART 5 — EMPLOYER/PLAN ADMINISTRATOR TO COMPLETE THIS SECTION

Name of company/organization	Division	Sub-division (if applicable)	Class	Section ID

Applicant's occupation	PBC office use: Occ. code	Employment type
		☐ Full-time ☐ Part-time ☐ Retired ☐ Hour bank ☐ Other: _____

Payroll number	Date of full-time hire (mm-dd-yyyy)	Date of rehire (mm-dd-yyyy)	Applicant's salary		Hours per week
			$ _____	☐ Hourly ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually	

If we have questions, how can we contact you? ☐ **Telephone:** _____ ☐ **Email:** _____

PART 6 — EMPLOYEE AND EMPLOYER/PLAN ADMINISTRATOR SIGNATURES

I agree to the conditions of the contract between my employer/plan administrator and Pacific Blue Cross/BC Life 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/BC Life up to the amount advanced to me pending such settlement or judgement.

I consent to Pacific Blue Cross/BC Life collecting, using and disclosing my personal information where reasonably necessary for the purposes of my enrolment or coverage under this group plan. I consent to the disclosure of my personal information to agents and representatives of Pacific Blue Cross/BC Life 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 contract between Pacific Blue Cross/BC Life and my employer/plan administrator; and to the retention, use and disclosure of my personal information in accordance with the Pacific Blue Cross/BC Life privacy policy.

The privacy policy is available from your employer/plan administrator, online at www.pac.bluecross.ca or by calling Pacific Blue Cross/BC Life at 604 419-2000.

Applicant's signature	Applicant's full name (print)	Date (mm-dd-yyyy)
X		
Employer/Plan administrator's signature	**Employer/Plan administrator's full name and title (print)**	**Date (mm-dd-yyyy)**
X		

PART 7 — WAIVER OF GROUP BENEFITS: Complete this section if waiving benefits

The Pacific Blue Cross Extended Health Care (EHC) plan is not the same as coverage under a government health/medical plan in any province or territory. If another plan covers you/your dependent(s) for EHC or Dental benefits, you may waive such benefits under this plan. Before you sign this form, read your employee booklet or ask your employer to explain the benefits to you. You should fully understand all the benefits and plan rules.

SECTION A — Waiver certified by employer

I do not want coverage for the following: ☐ Extended Health Care ☐ Dental Care ☐ For myself and my dependents ☐ Dependents only

I do not want coverage for the following BC Life benefits: ☐ Group term life ☐ Accidental death & dismemberment ☐ Short-term disability ☐ Long-term disability ☐ Dependent life ☐ Critical illness

EMPLOYER/PLAN ADMINISTRATOR — I hereby certify that: minimum participation requirements, as stipulated in the contract, have been met; this plan requires members/employers to contribute to the cost of coverage; benefit coverage is not a condition of employment.

Employer/Plan administrator's signature	Date (mm-dd-yyyy)
X	

SECTION B — Waiver due to coverage under another plan

I choose to waive the benefit(s) below because I am covered by another plan (named in *Part 4 — Coordination of Benefits*):
☐ Extended Health Care ☐ Dental care ☐ For myself and my dependents ☐ Dependents only

If the other plan terminates, I understand that there may be time limits for applying for coverage under this Pacific Blue Cross plan. If I apply late, or if I apply while the other plan is still active, I understand that dental coverage may be restricted to $250 per person for the first year, and/or my dependents and I will have to provide evidence of good health, and Pacific Blue Cross may decline to cover me or my dependents.

Employee signature is required for SECTIONS A and B

I have been offered the opportunity to participate in my employer's benefits plan under the policy number(s) on page 1. I have carefully studied the benefits and the plan rules, and I understand that if I apply at a later date for any benefit(s) that I am now waiving, as explained above, dental coverage may be restricted to $250 per person for the first year of coverage, and/or I will be required to prove, at my own expense, that I and my dependents are in good health. Pacific Blue Cross and/or BC Life reserve the right to refuse my application if my health or my dependents' health is not considered satisfactory.

Employee's signature	Date (mm-dd-yyyy)
X	

PART 8 — ADDITIONAL INFORMATION