PACIFIC BLUE CROSS™ BC Life®

PBC office use

PBC / BC Life Application for Group Benefits

❑ New applicant ❑ Reinstatement

Employer/Plan Administrator

Group Number	Effective Date
Dental	yyyy-mm-dd
EHC	yyyy-mm-dd
Other ❑ D ❑ E	yyyy-mm-dd
BC Life	yyyy-mm-dd
ID number (see page 2 for details)	

Applicant

First name	Surname	Middle initial
Birth date (yyyy-mm-dd)	Sex ❑ Male ❑ Female	
Address		
City	Province	Postal code

Dependent number	Surname (if different from applicant)	First name	Middle initial	Birth date (yyyy-mm-dd)	Sex	Name of school or details of disability*
01	Spouse				❑ M ❑ F	
02	First child				❑ M ❑ F	
03	Second child				❑ M ❑ F	
04	Third child				❑ M ❑ F	

List any additional children in the Additional Information section on page 2.

**Complete this section if child is over age 21 and under the age of 25 and attending school full-time, or if child is disabled.*

Beneficiary Designation – *I designate as revocable beneficiary in the event of my death:*

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.

Full legal name	Birthdate	Relationship to you	Share of proceeds %
Full legal name	Birthdate	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

Coordination of Benefits

Were you covered within the last 6 months, or are you presently covered, under another group Dental or EHC plan? ❑ Yes ❑ No

Name of insurance company	Group/policy number	ID or certificate number

Benefits covered under the other plan: ❑ EHC ❑ Dental

Is the plan still active? ❑ Yes ❑ No If no, state the termination date: (yyyy-mm-dd)

Employer/Plan Administrator – Complete this section

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

Applicant's occupation	Employment type	Employee number

Date of full-time hire (yyyy-mm-dd)	Date of rehire (yyyy-mm-dd)	Applicant's earnings	Hours per week
		❑ Hourly ❑ Weekly ❑ Biweekly ❑ Monthly ❑ Annual	

If we have questions about this application how can we contact you?	Telephone number	E-mail address

Employee and Employer/Plan Sponsor Signatures

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

I understand and consent that some of the personal information provided by me and my dependents under this group plan may be disclosed to agents and representatives of PBC/BC Life and other providers/insurers and their agents and representatives for the purposes of assessing and providing benefits coverage. I also understand and consent to the disclosure of this personal information to my employer/plan sponsor when required or permitted by contract between PBC/BC Life and my employer/plan sponsor; and to the retention, use and disclosure of this personal information in accordance with PBC/BC Life Privacy Policy.

A copy of the privacy policy is available from your employer/plan sponsor, or by contacting PBC/BC Life (604 419-2000), or online at pac.bluecross.ca

Signature of applicant	Date	Signature of employer/plan sponsor	Date

Full name of applicant	Name and title

0553.002 30-20-200 11/09 ACES TEST CUPE1816

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PBC / BC Life
Application for Group Benefits

What you need to know about this form

APPLICANT

- List all your dependants (your spouse and children) even if they are waiving coverage.
- You may waive Dental Care and Extended Health Care coverage if you have similar coverage under another plan. Otherwise, these and other benefits may be waived if the group plan rules specifically allow you to do so. If you are waiving benefits, complete the Waiver of Group Benefits section.
- If you have a disabled child, provide complete details of the disability such as the nature of the disability, date of onset and prognosis for recovery. His or her coverage will be continued beyond the normal age permitted under your plan if certain criteria are met.
- Sign and date the application and submit it to your employer or plan administrator as soon as possible. *Time limits may apply*.

EMPLOYER/PLAN ADMINISTRATOR

- Use this form to add or reinstate applicants. Use a Change form to: transfer a member from one group to another; add or terminate dependents; or report changes.
- For privacy reasons, Pacific Blue Cross does not require a new employee's Social Insurance Number (SIN). If your plan uses SINs and your employee does not wish to provide his/hers, leave the ID number blank and we will assign a unique nine-digit number. Indicate the group number(s) and ID number for a reinstated employee. A copy of the PBC/BC Life Privacy Policy is available by contacting PBC/BC Life or online at pac.bluecross.ca
- The applicant's occupation (be specific), class code and earnings are required only if your plan includes BC Life benefits.
- Date of hire means the date the applicant started working as an eligible employee as defined in your group contract/policy (not necessarily the first day of work). For example, if an employee was hired on June1 on a casual basis, working 8–12 hours per week, and then on September 1 was hired on a permanent part-time basis, working 20 hours per week, and as such qualified for benefits under your plan, September 1 would be the date of hire.
- Include department code and/or employee number if it is required by your plan, for example if your invoices or ID cards are sorted by one of those numbers.
- The applicant and dependents will be enrolled for all benefits covered by your plan, unless the waiver of group benefits section is completed and signed by the employer and employee.
- Mail to PBC/BC Life Member Administration, PO Box 7000 Vancouver BC V6B 4E1
- Or fax to 604 419-2149. *If you fax this application, do not mail the original*.

Waiver of Group Benefits – Complete this section if waiving benefits

The Pacific Blue Cross (PBC) 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.

I do not want coverage for the following:

❑ Extended Health Care ❑ For myself and my dependents

❑ Dental Care ❑ 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 – I hereby certify that:

1) Minimum participation requirements, as stipulated in the contract, have been met.
2) This plan requires members/employers to contribute to the cost of coverage.
3) Benefit coverage is not a condition of employment.

Employer's signature	Date

I choose to waive the benefit(s) below because I am covered by another plan (named in Coordination of Benefits section):

❑ 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 PBC 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 PBC may decline to cover me or my dependents.

EMPLOYEE – *I have been offered the opportunity to participate in my employer's group benefits plan under the group 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. PBC 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

Additional Information (if required)

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