SASKATCHEWAN BLUE CROSS®
516 2nd Avenue North, PO Box 4030
Saskatoon, SK S7K 3T2

INDIVIDUAL APPLICATION FOR GROUP BENEFITS

GRPA 1003-A

EMPLOYEE INFORMATION

Last Name | First Name | ☐ Home ☐ Work ☐ Mobile

Date of Birth (YYYY/MM/DD) | Phone Number

Address

City | Province | Postal Code

Marital Status: ☐ Single ☐ Legally Married ☐ Common-Law

Sex: ☐ Male ☐ Female

If common law: Commencement Date of Co-habitation (YYYY/MM/DD): _____

TO BE COMPLETED BY EMPLOYER OR ADMINISTRATOR

Name of Employer: _____

Hire Date: (YYYY/MM/DD) _____ Policy: _____

Occupation: _____ Division: _____

Class: _____

Earnings: $ _____

☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly

Payroll Number: _____

HSA Bank Load: _____

PSA Bank Load: _____

Hours Worked per Week: _____

Completed for Employer by: _____

Signature | Date (YYYY/MM/DD)

DEPENDENT INFORMATION

If more space is required, please attach a separate page listing all information below.

	Last Name	First Name	Birth Date YYYY	Birth Date MM	Birth Date DD	Sex M/F	Dependent Status: Student (College/ University)	Dependent Status: Disabled
Spouse								
Child								
Child								
Child								

BENEFICIARY DESIGNATION

In accordance with the terms and conditions of the Group Life Contract between the employer indicated below and Blue Cross Life Insurance Company of Canada, I revoke all previous appointments of beneficiary and hereby appoint the following as beneficiary entitled to receive the proceeds arising by reason of my death (in equal shares, unless otherwise designated).

Beneficiary Last Name	First Name	Age	Relationship	Percentage
				%
				%
				%

TRUSTEE DESIGNATION (COMPLETE IF BENEFICIARY IS UNDER AGE 18):

I hereby appoint the trustee named here to receive any amount due my beneficiary under age 18 and authorize such trustee to spend all or any portion of such amount and the income from it for the maintenance and education of such minor.

Last Name | First Name

ACKNOWLEDGMENT & CONSENT

I understand that the personal information I have given, as well as any other personal information currently held or provided in the future by Saskatchewan Blue Cross, Blue Cross Life Insurance Company of Canada and/or its agents may be collected, used, maintained and disclosed for the purposes of determining eligibility for coverage, underwriting, administering products and services, audit and investigation, confirming my identity, maintaining my relationship with Saskatchewan Blue Cross, and to help develop and recommend suitable products and services to me.

Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These include other Blue Cross® organizations, and/or their authorized agents/brokers, representatives, licensed physicians, practitioners or other healthcare providers, hospitals, clinics or other medical facilities, other health and life insurers and reinsurers, MIB, Inc., employers (past and present) government and regulatory authorities, and other third parties only when needed for a purpose stated above.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, coverage may be denied or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding the privacy policies of Blue Cross and/or the collection, use or disclosure of my personal information, I can visit www.sk.bluecross.ca or call 1-800-USEBLUE®.

A photocopy of this authorization shall be as valid as the original.

OPTIONAL LIFE COVERAGE

State total amounts in units of $10,000

☐ Employee ☐ Spouse

Employee Amount ($) | Spouse Amount ($)

OPTIONAL AD&D

☐ Employee ☐ Employee & Family

Employee Amount ($)

WAIVER OF BENEFITS

☐ Waive ALL Benefits ☐ Waive Only:

Reason: _____

COORDINATION OF BENEFITS

Do you or any of your dependents have alternate Health and/or Dental coverage?

☐ Yes ☐ No

If Yes, please complete the following:

Health: ☐ Single ☐ Couple ☐ Family

Dental: ☐ Single ☐ Couple ☐ Family

Insurer | Policy No.

I.D. Number | Coverage Effective Date (YYYY/MM/DD)

Signature of Applicant | Signature of Witness | Date (YYYY/MM/DD)