SASKATCHEWAN BLUE CROSS®

516 2nd Avenue North, PO Box 4030
Saskatoon, SK S7K 3T2

INDIVIDUAL APPLICATION FOR GROUP BENEFITS

GRPA-1003A

EMPLOYEE INFORMATION

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

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

Street Address

City/Town | Province | Postal Code

Email Address

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

Sex*: ☐ Male ☐ Female ☐ Intersex ☐ Undisclosed

Smoking Status: ☐ Smoker ☐ Non-Smoker

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: _____

Hours Worked per Week: _____

PWA Bank Load: _____

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/I/U	Dependent Status: Student (College/University)	Dependent Status: Incapacitated
Partner								
Child								
Child								
Child								

***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 your sex may differ from your gender identity.

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.

Trustee Full Name | Phone Number

ACKNOWLEDGMENT & CONSENT

I declare that the answers to the questions on this form are complete and accurate.

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, adjudicating and paying claims, administering products and services, audit and investigation, confirming my identity, maintaining my relationship with Saskatchewan Blue Cross and helping to 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/representatives, licensed physicians, practitioners or other healthcare providers, hospitals, clinics or other medical facilities, other health and life insurers and reinsurers, MIB, LLC, 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 in writing; 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 Saskatchewan Blue Cross and/or the collection, use or disclosure of my personal information, I can visit **www.sk.bluecross.ca** or call 1.800.667.6853. A photocopy of this authorization shall be as valid as the original.

Signature of Applicant | Date (YYYY-MM-DD)

OPTIONAL LIFE COVERAGE

State total amounts in units of $10,000

☐ Employee ☐ Partner

Employee Amount ($) | Partner Amount ($)

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:*

Cardholder's Name | Date of Birth (YYYY-MM-DD)

Health: ☐ Single ☐ Couple ☐ Family

Dental: ☐ Single ☐ Couple ☐ Family

Insurer | Policy Number

ID Number | Coverage Effective Date