SASKATCHEWAN BLUE CROSS®

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

INDIVIDUAL APPLICATION FOR GROUP BENEFITS — HEALTH & DENTAL ONLY

EMPLOYEE INFORMATION

Last Name | First Name

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

☐ Home ☐ Work ☐ Mobile

Street Address

City/Town | Province | Postal Code

Email Address

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

Sex*:
☐ Male ☐ Female ☐ Intersex ☐ Undisclosed

If common-law — commencement date of co-habitation (YYYY-MM-DD): _____

Smoking Status:
☐ Smoker ☐ Non-Smoker

☐ Health & Dental Benefits ☐ Health Spending Account Benefits
☐ Personal Wellness Account Benefits

TO BE COMPLETED BY EMPLOYER OR ADMINISTRATOR

Name of Employer: _____

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

Occupation: _____ Division: _____

Payroll Number: _____ Class: _____

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.

WAIVER OF BENEFITS

I have been given the opportunity to apply for coverage but do not wish to participate. I understand that I will not be able to enrol in these plans at a later date without the mutual consent of my employer and Saskatchewan Blue Cross.

☐ 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

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

Insurer | Policy Number | ID Number | Coverage Effective Date (YYYY-MM-DD)

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)