MEDAVIE BLUE CROSS™

644 MAIN ST PO BOX 220 MONCTON NB E1C 8L3
230 BROWNLOW AVE DARTMOUTH PO BOX 2200 HALIFAX NS B3J 3C6
FOR ALL INQUIRIES: 1-800-667-4511

Personal Health Plan Transfer

elements

Please print in ink or type information.

APPLICANT'S PERSONAL INFORMATION

Applicant's Last Name (Applicant must be age 16 or older): ______ First Name: ______

Language Preference: ◯ English ◯ French Occupation: ______

E-mail address: ______

Address (Street & No.): ______

City/Town: ______ Province: ______ Postal Code: ___ ___

Telephone No.: ___-___-____ HOME ___-___-____ WORK ___-___-____ MOBILE

How would you like us to contact you? ◯ E-mail ◯ Mail How would you like to receive your policy booklet? ◯ Electronic ◯ Print

One of the following coverages must be chosen:	You may add any additional benefits to the coverage		
◯ **Entry health benefits 60%** **OR** ◯ **Essential health benefits 70%** **OR** ◯ **Enhanced health benefits 80%** If 65: ◯ Travel ◯ No Travel	◯ **Essential drug benefits 70%** **OR** ◯ **Enhanced drug benefits 80%**	◯ **Entry dental benefits 60%** **OR** ◯ **Essential dental benefits 70%** **OR** ◯ **Enhanced dental benefits 80%**	◯ **Critical Illness** ◯ **Hospital Cash** ◯ **Assured Access** Payment for the Assured Access module is required in order to retain coverage under Individual Assured Access.

Requested effective date of Policy: Please begin my coverage on the 1st day of (month/year): ______

Please indicate your current Medavie Blue Cross coverage information:

ID Number: ______ Policy Number: ______

INDIVIDUAL REGISTRATION

First Name	Last Name	Sex M/F	Date of Birth DD MM YY	Please (✓) if you or your dependents **DO NOT** wish the following coverages: Drug	Dental	Full-Time Student
Applicant	00				N/A	
Spouse**	01				N/A	
Child	02					
Child	03					
Child	04					
Child	05					

**Spouse shall mean an individual who is married to the applicant, or in a conjugal relationship for at least one year or resides at the same address as the applicant.

AGREEMENT AND CONSENT

I, the undersigned, hereby apply for the benefits offered under the Elements Plan from Medavie Blue Cross, as outlined in the Elements Plan policy. I confirm that the information I have provided in this application is accurate and truthful.

I understand that the personal information provided herein, as well as any other personal information currently held or collected in the future by Medavie Blue Cross and/or Blue Cross Life Insurance Company of Canada, may be collected, used or disclosed to administer the terms of my policy or the group policy of which I am an eligible member, to recommend suitable products and services to me and to manage Medavie Blue Cross's business. Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These third parties include other Blue Cross organizations, health care professionals or institutions, life and health insurers, government and regulatory authorities and other third parties when required to administer and manage the benefits outlined in the policy of which I am an eligible member.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time, however, in some instances doing so may prevent Medavie Blue Cross from providing me with the requested coverage or benefits. I understand why my personal information is needed and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure.

I authorize Medavie Blue Cross to collect, use and disclose my personal information as described above.

Important: I understand the terms and benefit coverage under the Elements health plan may differ from coverage under other Medavie Blue Cross personal health plans including Options Plus, Options and Select.

Dated on this ______ day of __ year ____.

Signature of Applicant: ______ Signature of Spouse: ______
(as defined in policy)

A photocopy of this authorization shall be as valid as the original. This consent complies with federal and provincial privacy laws. For additional information regarding Medavie Blue Cross's privacy policies, visit www.medavie.bluecross.ca or call 1-800-667-4511.

BILLING - PRE-AUTHORIZED DEBIT (PAD)

Name of Payer: ____________________ Telephone Number: ____________

Address: ____________________

City/Town: ____________ Province: ________ Postal Code: ________

BANK ACCOUNT INFORMATION - PLEASE PRINT
Please attach a void cheque.

Financial Institution (FI): ____________________ Telephone Number: ____________

Address: ____________________

City/Town: ____________ Province: ________ Postal Code: ________

FI Transit Number: (branch - 5 digits; FI - 3 digits) FI Account Number:

Type of Service: ◯ Personal ◯ Business

I/We authorize Medavie Blue Cross and the financial institution designated (or any other financial institution I/we may authorize at any time) to begin deductions as per my/our instructions for recurring payments and/or one-time payments, from time to time, for payment of insurance premiums. Regular monthly payments will be debited to my/our specified account on the first business day of every month. Medavie Blue Cross will not provide monthly pre-notification but will provide 30 days notice if the deduction is subject to change. Medavie Blue Cross will obtain my/our authorization for any other one-time or sporadic debits. Medavie Blue Cross requires written notification of any changes to banking information.

This authority is to remain in effect until Medavie Blue Cross has received written notification from me/us of its change or termination. This notification must be received at least thirty (30) business days before the next debit is scheduled. This notification must be sent to the Administration Department of Medavie Blue Cross. I/We may obtain a sample cancellation form or more information on my/our right to cancel a PAD Agreement at my/our financial institution or by visiting www.cdnpay.ca.

I/We have certain recourse rights if any debit does not comply with this agreement. For example, I/we have the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. To obtain a form for a reimbursement claim, or for more information on my/our recourse rights, I/we may contact my/our financial institution or visit www.cdnpay.ca.

Date: ____________

Signature(s) of Bank Account holder(s): ____________________

DIRECT DEPOSIT

Eligible Benefits will be reimbursed through electronic funds transfer (direct deposit). I choose to use the same banking information as:
◯ Billing ◯ Use the banking information below. I may cancel this authorization at any time by giving written notice to Medavie Blue Cross.

BANK ACCOUNT INFORMATION - PLEASE PRINT
Please attach a void cheque.

Financial Institution: ____________________ Telephone Number: ____________

Address: ____________________

City/Town: ____________ Province: ________ Postal Code: ________

FI Transit Number: (branch - 5 digits; FI - 3 digits) FI Account Number:

Date: ____________ **Signature(s) of Bank Account holder(s):** ____________________

FOR AGENT USE ONLY

I hereby certify that, as an agent for Medavie Blue Cross, I have informed the applicant of the importance of making full and accurate disclosure of the matters covered in this application and that any misrepresentations or omissions may give Medavie Blue Cross the right to cancel the contract of insurance and refuse coverage under the policy. I have disclosed the company or companies I represent and any conflicts of interest they may have with respect to this transaction and that I may receive a salary, commissions or other forms of compensation for the sale of insurance company products.

Agent's Name: ____________ Agent's Number: ____________

Address: Box 1200 Station Main

City/Town: ____________ Province: ____________ Postal Code:

Telephone Number: - - Fax Number: - -

E-mail address: ____________________

Agent's Signature: ____________________

Agent Comments: ____________________

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