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Application for Group Benefits Program

Healthcare Benefit Trust
Joint Community Benefits Trust
Joint Facilities Benefits Trust
Joint Health Science Benefits Trust

Mailing Address:
PO Box 7000, Vancouver, BC V6B 4E1
Street Address:
4250 Canada Way, Burnaby, BC
Fax: 604 419-2149

❑ New applicant
❑ Reinstatement

Employer/Plan Administrator – complete this section	
Policy 50000	**Effective date** (mm/dd/yyyy)
☐ Dental	
☐ EHC	
Benefits ID #	

Applicant – Complete this section

First name	Last name	Middle initial	Sex ☐ M ☐ F	Birthdate (mm/dd/yyyy)

Address	City	Province	Postal code

	First name	Last name	Middle initial	Birthdate (mm/dd/yyyy)	Sex	Relationship to you
Spouse					Sex ☐ M ☐ F	☐ Married ☐ Common-law
1st child					Sex ☐ M ☐ F	
2nd child					Sex ☐ M ☐ F	
3rd child					Sex ☐ M ☐ F	
4th child					Sex ☐ M ☐ F	

If child is over plan's age limit (e.g., 19 or 21) and attending school full-time, attach the Application for Over-Age Dependent Child. If child is disabled, state details of disability to apply for coverage beyond plan's age limits. Attach completed Disabled Dependent Application.

Were you or your dependents covered within the last 6 months, or are you presently covered, under another group Dental or EHC plan? ☐ Yes ☐ No If yes, provide:

Insurance company	Name of cardholder of other plan	Group/policy number	Effective date	ID number

Employment type: ☐ Regular full time ☐ Regular part time ☐ Retiree

Benefits covered under other plan: ☐ EHC ☐ Dental Is the plan still active? ☐ Yes ☐ No If no, state termination date: (mm/dd/yyyy)

I agree to the conditions of the contract between Pacific Blue Cross (PBC) and one of the health and welfare trusts listed above (referred to in this authorization as the "Trust"). *If you require confirmation of which trust applies to you, contact your union or your employer.* If the contributions or a portion are employee-paid, I authorize my employer to deduct the required contributions from my earnings. I understand that the Trust uses my Social Insurance Number to create a Benefits Identification Number that is unique to me and that is used to identify me and to administer the benefit plan. I confirm that the information I have provided is true and complete. If I should receive a settlement or a judgment against a liable third party for benefits covered under my group plan, I agree to, and authorize the party to, reimburse PBC up to the amount advanced to me pending such settlement or judgment.

I understand and consent that some of the personal information provided by me and my dependents under this group plan ("Personal Information") may be disclosed to agents and representatives of PBC as claims paying agent under this group plan, and to other providers/insurers and their agents and representatives for the purposes of assessing and providing benefit coverage. I also understand and consent that the Personal Information may be disclosed to the Trust and agents of that Trust (which agents may include the Healthcare Benefit Trust). I understand that PBC will not disclose the Personal Information to my employer except to the extent that such disclosure is required for the purposes of having my employer complete this form, and except when required or permitted by law. I understand that PBC shall collect, use and disclose this Personal Information in accordance with its privacy policy. *A copy of the privacy policy is available by contacting PBC and is also available at www.pac.bluecross.ca.*

☐ I have read the above terms and conditions. ☐ I hereby declare that all the information provided in this application is true and complete.

Signature of applicant	Date (mm/dd/yyyy)	Email address

Employer / Plan Administrator – Complete this section

Name of organization	Division	Sub-division	Class code

Applicant's occupation	Employment type: ☐ Regular full time ☐ Regular part time ☐ Casual

Date of employment (mm/dd/yyyy)	Date of eligibility (mm/dd/yyyy)	Date of rehire/return from leave (mm/dd/yyyy)	Hours worked per week

If we have questions about this application, how can we contact you? ☐ Phone ☐ Email Phone (ten digits) Email address

☐ I have read the above terms and conditions. ☐ I hereby declare that all the information provided in this application is true and complete.

Signature of employer	Date (mm/dd/yyyy)

CARESnet® provides Pacific Blue Cross members with secure online access to their personal health and dental benefit information. When you receive your ID card, visit www.pac.bluecross.ca to register for CARESnet®