



APPLICATION FOR GROUP BENEFITS



for PBC office use only

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

- New Applicant
Reinstatement

Table with 4 columns: Group Number, Section, Plan code, Effective Date (mm/dd/yy). Rows include Dental, EHC, Other, BC Life, and ID Number (e.g., SIN).

Applicant - Complete this section

Main applicant information form including Surname, First name, Middle initial, Birthdate, Sex, Provincial Health Plan Number, Address, City, Province, Postal code, and dependent information.

Employer/Plan Administrator - Complete this section

Employer information form including Name of company/organization, Applicant's occupation, Class code, Department code, Employee number, Date of full time hire, Date of rehire, Applicant's earnings, Hours per week, and Is waiver card attached?

I agree to the conditions of the contract between my plan sponsor and Pacific Blue Cross/BC Life and authorize my employer to deduct required contributions from my earnings. By providing my Social Insurance Number, I authorize Pacific Blue Cross/BC Life to use it for identification purposes only.

I confirm that this applicant is eligible to apply for coverage.

X Signature of applicant Date

X Signature of employer/Plan administrator Date

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APPLICANT, please:

- Read these instructions carefully before you start writing. Ask your employer or plan administrator for help if necessary.
- List all your dependents (your spouse and children) whether or not you require coverage for them. If you have more than 4 children, please provide the required information below.
- You may waive Dental Care and Extended Health Care if you have similar coverage under another plan. Otherwise, these and other benefits may be waived if the group plan rules specifically allow you to do so. If you are waiving benefits, complete a Waiver of Group Benefits form.
- If your plan includes Group Life or Accidental Death & Dismemberment Insurance provided by BC Life, name at least one beneficiary (and trustee, if necessary); otherwise these benefits will be paid to your estate in the event of your death. If you make an error, sign or initial beside the correction.
- If you have a disabled child, provide complete details of the disability such as nature of the disability, date of onset, and prognosis for recovery. His or her coverage will be continued beyond the normal age permitted under your plan if certain criteria are met.
- Sign and date the application, and submit it to your employer or plan administrator as soon as possible. **Time limits may apply.**

EMPLOYER/PLAN ADMINISTRATOR, please:

- Use this form to add or reinstate applicants only. Use a change form to: transfer a member from one group to another, add or terminate dependents, and report changes.
- Indicate the group number(s), section and plan codes and ID number. Indicate the effective date for each benefit **only if** Pacific Blue Cross and/or BC Life has specifically instructed you to do so; otherwise leave the effective date fields blank. Ordinarily, Pacific Blue Cross/BC Life will determine the effective date.
- The applicant's occupation (be specific), class code and earnings are required only if your plan includes BC Life benefits.
- Date of hire means the date the applicant started working as an eligible employee as defined in your group contract/policy (not necessarily the first day of work). For example, if an employee was hired on June 1, 2004, on a casual basis working only 8 - 12 hours per week, and then on September 1, 2004, was hired on a permanent part-time basis working 20 hours per week and as such qualified for benefits under your plan, indicate September 1, 2004, as the date of hire.
- Include the department code and/or employee number if it is required by your plan, e.g., if your invoices or ID cards are sorted by one of these numbers.
- The applicant (and dependents) will be enrolled for all benefits, unless a waiver of group benefits form is submitted with this application.
- Ensure that the applicant has completed all relevant sections. Beneficiaries and trustee, where applicable, should be written in the applicant's own handwriting.
- Ensure that the application form is signed and dated by both the applicant and you.
- You may fax this to us at 604 419-2149. If you fax us this application, **do not** send us the original.

(Note: It may not always be possible for Applicants to waive coverage.)

Additional dependent information (cont'd)

Dep. no.	Surname* (* not required if same as yours)	First name	Middle initial	Birthdate (mm/dd/yy)	Sex	Relationship to you
06	5th child				<input type="checkbox"/> M <input type="checkbox"/> F	
07	6th child				<input type="checkbox"/> M <input type="checkbox"/> F	
08	7th child				<input type="checkbox"/> M <input type="checkbox"/> F	

If child is over plan's age limit (e.g., 19 or 21) and attending school full-time, provide name of school. If child is disabled, state details of disability to apply for coverage beyond plan's age limits.

Dep. number _____ Name of school or details of disability _____

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