BLUE CROSS®

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

INDIVIDUAL APPLICATION FOR GROUP BENEFITS

TO BE COMPLETED BY EMPLOYEE

Please print in ink or type information.

LAST NAME

ADDRESS - STREET & NO.

CITY OR TOWN

PROVINCE

POSTAL CODE | TELEPHONE

FIRST NAME	INITIAL	Surname, if different from employee *		SEX M/F	BIRTH DATE Day	Mo.	Year	Dependent Status
EMPLOYEE			00					E - Student (College / University) S - Disabled
SPOUSE			01					
CHILDREN			02					
			03					
			04					
			05					

❑ Legally Married ❑ *Common-Law, if yes provide commencement date of co-habitation _____

BASIC COVERAGES APPLIED FOR:

❑ Life ❑ AD & D ❑ Health
❑ Dependent Life ❑ Weekly Indemnity ❑ Dental
❑ Critical Conditions ❑ Long Term Disability

Health / Dental Coverage: ❑ Single ❑ Couple ❑ Family
❑ Waived → complete Waiver of Benefit area below

OPTIONAL LIFE
(Complete Optional Group Life Insurance Statement of Health form for coverage)
❑ Employee Only ❑ Spouse Only
❑ Employee & Spouse

$ Employee Amount | $ Spouse Amount

OPTIONAL AD &D
❑ Employee Only
❑ Employee & Family

$ Employee Amount

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 _____

For Dependent Life, Critical Conditions, Optional Life and Optional AD & D, the employee is the beneficiary of the insured spouse and children.

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.

	Beneficiary Last Name	First Name	Initial	Relationship	Percentage
1.					
2.					
3.					

TRUSTEE DESIGNATION FOR BENEFICIARY UNDER AGE 18

Complete only if beneficiary is under age 18

Surname of Trustee | First Name | Middle Initial

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.

COORDINATION OF BENEFITS

Do you or any of your dependents have other coverage under any other insurer? ❑ Yes ❑ No

If Yes, complete the following: Effective Date of Coverage: _____ Name of the Other Insurer: _____

Please indicate the type of coverage: Health _____ Dental _____ Identification Number/Certificate Number: _____ Policy Number: _____

AUTHORIZATION AND CONSENT

I certify all the above information is true and complete. I have read and agree to the Authorization and Consent on the reverse of this form.

Dated at _____ this _____ day of _____ in the year _____

Signature of Witness | **Signature of Insured**

TO BE COMPLETED BY EMPLOYER

Name of Employer	Policy and Section Number	Class of Coverage - Health and/or Dental	Employer Class - Life and/or Income Replacement	Occupation

• Permanent Date Employed Day	Month	Year	Complete for Life and Disability Income Benefits: Earnings Per ❑ Hour ❑ Month ❑ Week ❑ Year $_____	• Hours Worked / Week	• Payroll No. (maximum 9 positions) 1 / 2	Completed for Employer by: Signature / Date

Blue Cross Life Insurance Company of Canada, an independent licensee of the Canadian Association of Blue Cross Plans, underwrites all life and disability income benefits.

FOR SASKATCHEWAN BLUE CROSS USE ONLY

I.D. Number	Policy and Section No.	Cross Reference I.D. From	Effective Date Day	Month	Year

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