MEDAVIE BLUE CROSS™

ESA Initial: _____
Peoplesoft Entry (MM/DD/YYYY): _____

Health & Dental Application (All Employee Groups)

❶ TO BE COMPLETED BY THE EMPLOYER

Name of Employer: **Nova Scotia Community College** Policy Number: **0007172**

Date of Hire/Rehire (MM/DD/YYYY):_____ Eligible Date of Coverage (MM/DD/YYYY): _____

Employee ID Number: W_____ Job Title: _____

Employee Group: ☐ Faculty/Professional Support ☐ Management Confidential/Operational Support

❷ EMPLOYEE AND FAMILY INFORMATION

Last Name:_____ First Name: _____

Sex: Male ☐ Female ☐ Other ☐ Date of Birth (MM/DD/YYYY): _____

Address: _____

City/Town:_____ Province:_____ Postal Code: _____

Select Health & Dental Coverage Applying for:	**Health** Single ☐ Family ☐	**Dental** Single ☐ Family ☐	*Is your spouse currently taking part in NSCC's Group Health and/or Dental Benefits as an employee of NSCC?* Yes ☐ No ☐

Spouse (if applicable):

First Name:_____ Last Name: _____

Sex: Male ☐ Female ☐ Other ☐ Date of Birth (MM/DD/YYYY): _____

Status: Married ☐ Common-Law ☐ Date of co-habitation if common-law (MM/DD/YYYY): _____

Dependent Children (if applicable):
Disabled: complete the Dependent with Disability form or *Student: complete the Overage Dependent form*

Last Name	First Name	Date of Birth (MM/DD/YYYY)	Sex (M/F/Other)	Dependent Status
				☐ Disabled ☐ Student (College/University)
				☐ Disabled ☐ Student (College/University)
				☐ Disabled ☐ Student (College/University)
				☐ Disabled ☐ Student (College/University)

❸ OTHER COVERAGE (CO-ORDINATION OF BENEFITS)

Do you or any of your dependents have coverage under any other plan? Yes ☐ No ☐

If yes, who has other coverage? Myself ☐ Spouse ☐ Dependent Children ☐

Name of Other Insurer:_____ Effective Date of Coverage (MM/DD/YYYY): _____

Policy Number:_____ ID Number: _____

Name of Employer: _____

Type of Coverage: Hospital ☐ Vision ☐ EHB ☐ Drugs ☐ Dental ☐ All ☐

❹ WAIVER OF COVERAGE

I have been given the opportunity to apply for coverage with NSCC. I **do not** wish to participate and therefore waive this offer by providing proof of alternate comparable coverage.

I understand that should I wish to apply for coverage for myself and/or my eligible dependents at a later date, that I am required to submit proof of termination of the alternate coverage *within 31 days of the termination of the coverage*, for application to the NSCC benefits plan. I also understand that if application not submitted with 31 days after losing alternate coverage, a completed statement of health, and insurer approval, will be required. I understand that I will not be able to enrol in these plans without the mutual consent of my employer and Medavie Blue Cross.

I waive the following group benefits **for myself***: Health ☐ Dental ☐ Both Health and Dental ☐

I waive the following group benefits for **my dependent(s)***: Health ☐ Dental ☐ Both Health and Dental ☐

I have attached proof (documentation) of comparable benefits coverage through an alternate plan. ☐

AUTHORIZATION

I certify that the information above is accurate and authorize payroll deductions, if required. I authorize Blue Cross to collect, use and disclose my personal information as described in the Privacy Consent section below.

Employee Signature:_____ Date (MM/DD/YYYY):_____

PRIVACY CONSENT

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 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 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.

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 privacy policies at Medavie Blue Cross, visit medaviebc.ca or call 1-800-667-4511.