C&C INSURANCE CONSULTANTS

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TRENT UNIVERSITY

# GROUP BENEFITS APPLICATION
## Health & Dental

Policy Number: 91940 Division Number: 001 / Trent CUPE 3908 Class: H

## 1 EMPLOYEE AND FAMILY INFORMATION

Employee Last Name: _____ Employee First Name: _____

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

Address (Street & Number): _____

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

Telephone Number: _____ Email: _____ ☐ English ☐ French

**Are all members of your immediate family eligible and enrolled with your provincial health plan such as OHIP, MSI, Pharmacare, Medicare etc.?**
☐ Yes ☐ No

**Spouse (if applicable)**

Last Name: _____ First Name: _____

Gender: ☐ Male ☐ Female Birth Date (DD/MM/YYYY): _____

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

**Dependent Children (if applicable)**

| First Name | Last Name | Date of Birth (DD/MM/YYYY) | Gender M/F | Dependent Status |
|---|---|---|---|---|
| | | | ☐ Male ☐ Female | ☐ Disabled ☐ Student - College/University |
| | | | ☐ Male ☐ Female | ☐ Disabled ☐ Student - College/University |
| | | | ☐ Male ☐ Female | ☐ Disabled ☐ Student - College/University |

**OTHER COVERAGE (CO-ORDINATION OF BENEFITS)**

Do you or any of your dependents have coverage under any other Plan? ☐ Yes ☐ No **If Yes, Complete the following:**

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

Policy Number: _____ ID Number: _____ **Type of Coverage:** ☐ Hospital ☐ Vision ☐ EHB ☐ Drugs ☐ Dental ☐ All

Name of Employer: _____

| Name of Person(s) insured under other policy | Date of Birth DD | MM | YYYY |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

| Name of Person(s) insured under other policy | Date of Birth DD | MM | YYYY |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## 2 WAIVER OF COVERAGE

☐ 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 Medavie Blue Cross. Also, I may be required to submit medical evidence of insurability at that time.

☐ I have been given the opportunity to apply for coverage. I do not wish to participate and waive this offer due to spousal coverage. I understand that I may be required to submit medical evidence of insurability should I apply 31 days after losing spousal coverage.

I do not want to participate in the following coverage**:** ☐ Health ☐ Dental ☐ Both Health and Dental

**For Québec Residents:** Participation in the Health coverage plan can only be declined due to spousal coverage. If declining the Health coverage, please complete your spouse's coverage information.

## 3 DIRECT DEPOSIT

I request that my benefits be paid through Electronic Funds Transfer (Direct Deposit).

☐ Yes ☐ No If yes is selected, please include a void cheque in your name and/or visit the Medavie Blue Cross website at medaviebc.ca.

I may cancel this authorization at any time by giving 30 days written notice to Medavie Blue Cross.

## 4 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 C&C Insurance Consultants Ltd., may be collected, used, or disclosed to administer the terms of my policy or the group policy of which I am an eligible member, and to manage C&C Insurance Consultants Ltd.'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 Blue Cross, 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 C&C Insurance Consultants Ltd. 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 C&C Insurance Consultants Ltd., call 1-888-918-5056.

## 5 AUTHORIZATION

I certify that the information above is accurate. I authorize C&C Insurance Consultants Ltd. to collect, use and disclose my personal information as described in the Privacy Consent section above.

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