MEDAVIE BLUE CROSS™

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EMAIL: MAAX.Policy.Administrators@medavie.bluecross.ca

New Nouveau Brunswick

(Ce formulaire est disponible en français au verso.)

APPLICATION FORM - EMPLOYEE BUSINESS TRAVEL - POLICY NUMBER 01420-000

Please complete the following form to receive your **Business Travel Card**, for health coverage while traveling out of province while representing the Province of New Brunswick. This coverage does not apply to any dependents who may travel with you. Return the completed form to Medavie Blue Cross for processing (contact information referenced above.)

Complete *ONLY* if: You do not have Province of New Brunswick health insurance coverage or, you have Travel coverage and that coverage is provided by an employer other that the Province of New Brunswick.

Please be sure to check the Government website travel.gc.ca/travel/advisories for any travel warnings, prior to travel. You may also contact Medavie Blue Cross at 1-800-667-4511 with any questions.

1. EMPLOYEE AND CONTACT INFORMATION

First Name: _____ Last Name: _____

Sex at Birth: ○ Male ○ Female Birth Date (JJ/MM/AAAA) : _____

Mailing Address: _____ Apt. Number: _____

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

Telephone Number: _____ Email Address: _____

Language: ○ English ○ French ☑ Travel Coverage ☑ Single

2. 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 www.medavie.bluecross.ca or call 1-800-667-4511.

3. TO BE COMPLETED BY THE EMPLOYER

Employer Name: _____

Policy Number: **01420** Division Number: **000**

Employer Signature: _____ Date (JJ/MM/AAAA) : _____

Telephone Number: _____ Effective Date of Travel Policy (JJ/MM/AAAA) : _____

Date of Employment (JJ/MM/AAAA) : _____

4. AUTHORIZATION

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

Employee Signature: _____ Date (JJ/MM/AAAA) : _____

Employee Signature: _____ Date (JJ/MM/AAAA) : _____