VESTCOR

RETIREE BENEFIT PLANS
TRANSFER APPLICATION FORM

New Nouveau Brunswick

Instructions:

1) For eligible employee's transferring to the Province of New Brunswick Retiree Plan, complete Section A in full. If premiums will be paid through pre-authorized debit/chequing, also complete section B and forward to your employer.
2) Employer - complete Section C in full and forward to either Medavie Blue Cross or Vestcor, as indicated at the bottom of the form.

Section A to be completed by Employee

Employee's Last Name	
Address (Street & No.)	
City or Town	Province
Postal Code	Phone Number ( ) -
Social Insurance Number -- --	Language Preference ☐ English ☐ French
Email Address	

Individual Registration

First Name	Initial		M/F	Birthdate DD	MM	YY	Dependent Status
Employee		00					E=Student College/ University) S=Disabled
Spouse		01					
Children		02					
		03					
		04					

1. Employee's Current Coverage:	Health with Travel	Dental	2. Select Coverage Being Transferred:	Health with Travel	OR	Health without Travel	Dental
Employee-Only (Single)	☐	☐ - *option* →	Employee-Only (Single)	☐		☐	☐
Employee + 1 Dependent (Two-Person)	☐	☐ - *options* →	Employee-Only (Single) **OR** Employee + Dependents (Family*)	☐ ☐		☐ ☐	☐ ☐
Employee + 2 or More Dependents (Family)	☐	☐ - *options* →	Employee-Only (Single) **OR** Employee + Dependents (Family*)	☐ ☐		☐ ☐	☐ ☐

**Family coverage is Employee + any number of eligible dependents.*

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.

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

Employee Signature: _____ Date: _____

Section B to be completed by Employee if premiums will be paid through Pre-Authorized Debit/Chequing

Pre-authorized Debit (PAD) Authorization: Attach a void cheque.

Financial Institution (FI): _____ Telephone Number : _____

Address: _____

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

CONSENT: I/We authorize Medavie Blue Cross and the financial institution designated (or any other financial institution I/we may authorize at any time) to begin deductions as per my/our instructions for recurring payments and/or one-time payments, from time to time, for payment of insurance premiums. Regular monthly payments will be debited to my/our specified account on the first business day of every month. **Medavie Blue Cross will not provide monthly notification but will provide 30 days notice if the deduction is subject to change.** Medavie Blue Cross will obtain my/our authorization for any other one-time or sporadic debits. Medavie Blue Cross requires written notification of any changes to banking information.

This authority is to remain in effect until Medavie Blue Cross has received written notification from me/us of its change or termination. This notification must be received at least thirty (30) business days before the next debit is scheduled. This notification must be sent to the Administration Department of Medavie Blue Cross. I/We may obtain a sample cancellation form or more information on my right to cancel a PAD Agreement at my/our financial institution or by visiting www.cdnpay.ca.

I/We have certain recourse rights if any debit does not comply with this agreement. For example, I/we have the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. To obtain a form for a reimbursement claim, or for more information on my/our recourse rights, I/we may contact my/our financial institution or visit www.cdnpay.ca.

Signature(s) of Bank Account holder(s): _____ Date: _____

Section C to be completed by Employer

Employer (specify name of Dept., Health Authority or School District)

_____

Employee's Group Policy Number

_____

Employee's Identification Number

_____

Date of last monthly deduction made by Employer _____

Covering employee for the month of _____

Transfer to Retiree Plan(s) in the month of _____

For coverage beginning the month of _____

_____ _____

Employer Signature Date

For payments from pre-authorized chequing, send completed form to:
Medavie Blue Cross
644 Main Street, P.O. Box 220
Moncton, N.B. E1C 8L3
or by email to: MAAX.Policy.Administrators@medavie.bluecross.ca
Inquiries: 1-800-667-4511
Fax: (506) 869-9653

For payments from pension deductions, send completed form to:
Vestcor
P.O. Box 6000,
Fredericton, N.B. E3B 5H1
Inquiries: 1-800-561-4012
Fax: (506) 457-7388

12/2023