RETIREE BENEFIT PLANS
TRANSFER APPLICATION FORM

Important Information:

- To be eligible to transfer in the Province of New Brunswick Retiree Benefits Plans, the employee and their dependents **must** have participated in the PNB Active Employee Plans immediately (at least one month) prior to the retirement date. For more information about your eligibility and the eligibility of your dependents, please refer to the Benefit Booklet for Retirees.
- Travel insurance coverage is only available with health coverage. If selecting travel, ensure you choose the same coverage (Single or Family) that you selected for your health coverage.
- For eligible employees transferring to the PNB Retiree Plan, complete Section A and B in full.
- Employer - complete Section C in full and forward to Medavie Blue Cross, as indicated at the bottom of the form.

Section A to be completed by Employee

Employee's Last Name		Individual Registration						
Address (Street & No.)		First Name	Initial	M/F	Birthdate DD	Birthdate MM	Birthdate YY	Dependent Status
City or Town	Province	Employee						E=Student (College/ University) S=Disabled
Postal Code	Phone Number	Spouse						
Social Insurance Number (Optional)	Language Preference ☐ English ☐ French	Children						
Employee Number **OR** Vestcor Reference Number								
Email Address								

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. In addition, I understand that the personal information provided herein will be provided to Vestcor if you choose payments from pension deduction.

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. Additional information regarding privacy policies at Vestcor may be submitted to Vestcor's Member Services team, by mail at P.O. Box 6000, Fredericton, NB, E3B 5H1, by phone at (506) 453-2296 or 1-800-561-4012, or by email at info@vestcor.org. In addition, Vestcor's Privacy Statement is available at www.vestcor.org/privacy.

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.

For digital signatures only

I, _____, hereby declare that I have validated the authenticity of the employee's digital signature.

Date: _____ Employee Signature:_____

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Section B to be completed by Employee - Premium payments by 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.

For digital signatures only

I, _____, hereby declare that I have validated the authenticity of the employee's digital signature.

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

Section C to be completed by Employer

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

Date of last monthly deduction made by Employer _____

_____

Covering employee for the month of _____

Employee's Group Policy Number

_____

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

Employee's Identification Number

_____

For coverage beginning the month of _____

Employer Signature: _____ Date: _____

For payments from pre-authorized chequing, Please send completed form to:

Medavie Blue Cross
644 Main Street, P.O. Box 220
Moncton, N.B. E1C 8L3

Inquiries: 1-800-667-4511
Fax: (506) 869-9653
or by email to: MAAX.Policy.Administrators@medavie.bluecross.ca