RETIREE BENEFIT PLANS
LATE APPLICATION FORM

Important Informations

- The late application process for Health and Travel coverage requires a *Statement of Health* be completed and submitted to the insurer with the present form. It can take up to three (3) months before you receive the medical underwriting decision. If approved, the Health and Travel coverage will be effective on the decision date by medical underwriting and the premiums will be deducted the first of the following month.
- 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.
- If adding a new spouse/dependent the retired employee must change from single to family coverage within 31 days following the date of marriage or one year of co-habitation.
- Surviving spouses of a PNB Retiree cannot add new spouses or dependents that have been acquired through re-marriage.

*In light of the implementation of the Federal Dental Program, the initiation of the late applicant process for dental coverage will be deferred until a comprehensive examination of all potential impacts has been conducted.

Requesting	**Health and Travel**	**Health Only**
Enrolment Retiree Only (Single coverage)	☐	☐
Enrolment Retiree + 2 or more dependents (Family coverage) **Family coverage includes the retiree + any number of eligible dependents.*	☐	☐
Adding one or more dependents *Retiree already has coverage and wants to add an eligible spouse and/or dependents.	☐	☐

Retiree Information

Last Name	First name	Initial(s)	Date of Birth (DD-MM-YY)	M/F	Telephone Number

Language Preference ☐ English ☐ French	Address (Street & No.)	City or Town	Province	Postal Code	Email Address

Name of your PNB employer at the time of your retirement:	Retirement Date

If you are already participating in the PNB Retiree Benefits Plans, please provide:	Blue Cross ID Number	Blue Cross Policy Number

If a new enrolment in the PNB Retiree Benefits Plans, the policy number is: **1418**

Dependent Information (for family coverage only)

Last Name	First Name	Initial(s)	Date of Birth (DD-MM-YY)	M/F	If Dependent Child is age 21 or older	
Spouse					Full-time Student	Special Dependent
Children					☐	☐
					☐	☐
					☐	☐

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Complete if enrolling/adding a spouse

If married, provide date of marriage (DD-MM-YY):	If common-law, provide date co-habitation began (DD-MM-YY):

Complete if dependent child is 21 years of age or older

If Full-Time Student:	Name of accredited school, college or university School Term (DD-MM-YY) From: To:
If Special Dependent:	Coverage is subject to approval by Medavie Blue Cross (MBC). The Special Dependent Questionnaire located at **www.medaviebc.ca/en/resources** must be completed and emailed, mailed or faxed to MBC.

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.

Retiree Signature: ____________________ **Date:** ____________________

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:** ____________________

Send completed form to:
Medavie Blue Cross
644 Main Street, P.O. Box 220
Moncton, NB E1C 8L3
Fax: (506) 869-9653
or by email to: MAAX.Policy.Administrators@medavie.bluecross.ca

For inquiries about the late application process, please contact the Member Services team at Vestcor, our Plan's Administrator, at 1-800-561-4012 or 506-453-2296 or refer to the Benefit Booklet for Retirees at www.gnb.ca/employeebenefits.