MANITOBA BLUE CROSS®

Substitute Teachers Health and Dental Plan Application

A. GENERAL INFORMATION

List all individuals to be covered under the applicant's Manitoba Blue Cross plan, indicating dependent's last name if different from applicant. All individuals listed must be Manitoba residents covered by Manitoba Health.

Last Name	First Name	Middle Initial	Gender	Date of Birth		
Applicant				DD	MM	YYYY
Spouse/Common-law				DD	MM	YYYY
Dependents				DD	MM	YYYY
				DD	MM	YYYY
				DD	MM	YYYY
				DD	MM	YYYY

Mailing Address	Postal Code	City	Province

Home Phone Number	Daytime Phone Number	Email Address

B. PLAN INFORMATION

I/We are applying for the plan with an effective date of: _____

NOTE: The plan will be effective the first day of the month.

a. Acceptance – Upon acceptance of this application Manitoba Blue Cross will confirm coverage through the issuance of identification cards within an effective date determined by Manitoba Blue Cross. The agreement will include: Plan application, and the Plan agreement.

Manitoba Blue Cross may amend the provisions of the agreement at any time by providing 30 days written notice to the plan member.

If the plan member is not satisfied with the plan agreement it may be returned to Manitoba Blue Cross for termination within twenty (20) days of receipt and all payments less claims paid will be refunded.

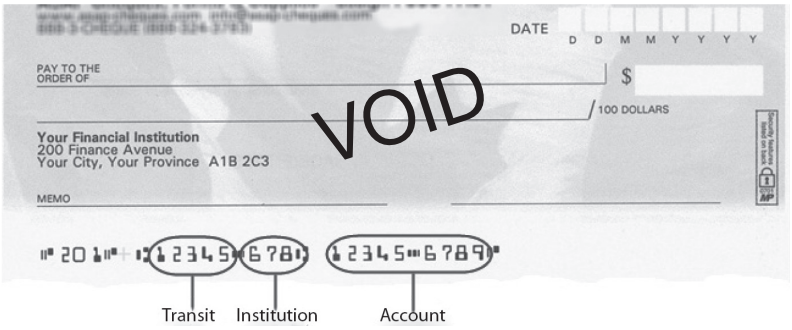
b. Rejection – In the event that this application is rejected, Manitoba Blue Cross will destroy all of the information provided to Manitoba Blue Cross relating to this application.

C. MONTHLY PRE-AUTHORIZED DEBIT AND DIRECT DEPOSIT OF CLAIMS AUTHORIZATION

Please complete the information below and enclose a void cheque.

Financial Institution Name	Transit Number	Institution Number	Account Number

For verification purposes, please enclose a cheque marked void.



Pre-Authorized Debit Agreement

I authorize Manitoba Blue Cross to perform a personal Pre-Authorized Debit (PAD) on the first business day for each billing period. The amount may vary. I will notify Manitoba Blue Cross in writing of any changes to my account information. I may revoke my authorization at any time, subject to providing notice of 30 days. For more information on my right to cancel a PAD agreement, I may contact my financial institution or visit www.cdnpay.ca. **I have certain recourse rights if any debit does not comply with this agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.**

I authorize Manitoba Blue Cross to transfer ALL claim payments to the Financial Institution indicated above. Please include all signatures required for cheque endorsement.

Authorized Signature _____ **Date** _____

Second Authorized Signature (if required) _____ **Date** _____

D. AUTHORIZATION AND CONSENT

Failure to complete this application in its entirety will result in delays. Upon receipt of a completed application with all the required information and verification of medical information, Manitoba Blue Cross will provide a response to this application for coverage within 30 days. Applicants, co-applicants and dependents must cooperate fully with Manitoba Blue Cross in verifying the information provided and understand that a failure to cooperate may lead to the application being rejected or the agreement being cancelled. If all the required information is not received within 60 days, the application will be closed.

I/we understand that the personal information provided herein as well as any other personal information currently held or collected in the future by Manitoba Blue Cross and /or Blue Cross Life Insurance Company of Canada may be collected, used, or disclosed to administer the terms of my/our plan; verify my/our eligibility for coverage; verify, assess and pay claims; develop and recommend suitable products and services to me/us; and to manage the company's business.

Depending on the type of coverage I/we carry, limited personal information may be collected from and/or released to a third party. These third parties include other Blue Cross Plans, health care professionals or institutions, health and life insurers, government and regulatory authorities, and other third parties when required to administer the benefits outlined in the plan of which I/we are an eligible member.

I/we certify that the member is authorized by his/her spouse and/or other adult dependents to disclose and receive information about them that is used solely for these purposes.

I/we understand that my/our personal information will be kept confidential and secure. I/we understand that I/we may revoke my/our consent at any time; however, if consent is withheld or revoked, the coverage may be denied or rescinded.

I/we understand why my/our personal information is needed and are aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding Manitoba Blue Cross's privacy policies I/we can contact Manitoba Blue Cross at 1.800.873.2583 or mb.bluecross.ca should I/we have questions as to the collection, use or disclosure of my/our personal information.

I/we authorize Manitoba Blue Cross to collect, use and disclose my/our personal information as described above.

A photographic copy of this authorization shall be as valid as the original. This consent complies with provincial and federal privacy legislation.

I/we have read and understand the entire application and certify that all questions are answered fully and completely. I/we understand that facts known by me/us or listed dependents – but not stated on the application – could result in the denial of coverage, denial of a claim or cancellation of the agreement.

Date _____ / _____ / _____
DD MM YYYY

This consent will be valid from this date, will continue while this agreement is in force and will end when agreement is cancelled.

Signature of Applicant _____

Please print name here _____

Signature of Spouse/Common-law _____

Please print name here _____

AGENTS USE ONLY

AGENT NUMBER
689

The Completed application can be emailed to bluechoice@mb.bluecross.ca or mailed to:

Manitoba Blue Cross
Attn: IP Sales
PO Box 1046 Stn Main
Winnipeg, MB R3C2X7