PACIFIC BLUE CROSS®

Application Form
UVic Retiree Plan

Pacific Blue Cross
PO Box 7000
Vancouver BC V6B 4E1

For office use only

POLICY 97090

Effective Date (mm-dd-yyyy)
/ /

Part 1 APPLICANT

Last name	First name	Initial	Date of birth (mm-dd-yyyy)	☐M ☐F

Address of residence	Ten digit area code and phone number

City	Province	Postal code	Email Address

Complete Mailing Address (if different than above)

Date of retirement (mm-dd-yyyy)	Effective date of retiree plan will commence on the first day of the month following retirement providing your application is received within 60 days of your group plan ending.

Part 2 SPOUSE (List only if applying for coverage)

Dep 01	Last name	First name	Initial	Date of birth (mm-dd-yyyy)	☐M ☐F

Part 3 PLAN OPTIONS – Please indicate with a ◉ below for coverage options

You must choose either Extended Health Benefits, Option 1 or Option 2. Refer to the brochure for coverage details.

☐ Option 1 - Extended Health Coverage: ☐ Single: $39.37 or ☐ Couple: $89.35 $1,000 Deductible per Calendar Year
☐ Option 2 - Extended Health Coverage: ☐ Single: $138.13 or ☐ Couple: $248.62 $100 Deductible per Calendar Year

☐ Optional Dental: ☐ Single: $60.80 or ☐ Couple: $115.52

Part 4 — PAYMENT METHOD (Choose one method below)

POLICY SPONSOR INFORMATION Bank account/credit card holder, only if different from the Applicant

First name	Last name	Daytime phone number (10 digits)

Street address	City	Province	Postal code

PAYMENT FREQUENCY

☐ **Monthly Pre-authorized debit (PAD)** — Attach a cheque marked VOID or a pre-authorized payment form provided by your bank that identifies your branch and account information. This will only apply to the payment being withdrawn from your banking account (PAD). If you wish to change your banking information to receive claims payments in that same account, please contact us. The only frequency available for PAD is monthly.
Pre-authorized payment account type: ☐ Business ☐ Personal.

☐ **Credit card** ☐ VISA ☐ MasterCard ☐ American Express

Name on credit card	Expiry date (mm/yyyy)

Once we receive your authorization form, we will contact you to obtain the credit card number.

Part 5 — AUTHORIZATION

I (We) authorize PBC to make deductions, from the credit card or bank account indicated, either through monthly regular recurring payments and/or one-time payments from time to time, for payment of all charges arising under the Member's policy. Each debit will occur on or about the first business day of the month, beginning on the effective date of coverage.
I (We) agree to waive the requirement for PBC to notify me (us) of this authorization before the first payment is processed and any subsequent monthly regular payment.
The withdrawal amount is considered variable under the Canadian Payments Association rules. PBC will provide me (us) at least three (3) business days written notice should there be a change in either the amount of the monthly regular payment or premium due date. Any notices, to be sent under this agreement, will be sent to the Member's most recent address that PBC has on record at the time a notice is sent. All persons, whose signatures are required to sign on this account, have signed this authorization.
Pacific Blue Cross may terminate coverage, or change the method of payment with written approval of the Policy Sponsor to another qualifying method, should a withdrawal be refused for any reason. Pacific Blue Cross will charge a fee for any withdrawal that is not honoured.
I (We) will notify PBC in writing of any changes in the account information or termination of this authorization within ten (10) business days prior to the next debit. I/We have certain rights if any debit does not comply with this agreement. To obtain more information on my/our recourse rights, I/we may contact my/our financial institution or visit payments.ca.

Account/card holder's signature	Second account/card holder's signature (if required)	Date (mm-dd-yyyy)
X	X	

Part 6 — APPLICANT SIGNATURE

I confirm that the information I have provided is true and complete. I understand that I and my dependents (if applicable) must be continuously enrolled under all applicable provincial health plans in order to participate in this contract.
If I should receive a settlement against a liable third party for benefits covered under this contract, I agree to, and authorize the third party to, reimburse Pacific Blue Cross up to the amount advanced to me pending such settlement or judgement.
I understand and agree that any injury that occurred on or before the date of this application or any sickness, the signs of which appeared on or before the date of this application, may not be covered. I understand that not accurately and fully disclosing all information requested on this application, could result in a denial of claims and a cancellation, or modification of the contract.
I understand and consent that some of the personal information provided by me and my dependents (if applicable) may be disclosed to agents and representatives of Pacific Blue Cross and other providers/insurers and their agents and representatives for the purposes of assessing and providing benefit coverage. I also understand and consent to the retention, use and disclosure of this personal information in accordance with Pacific Blue Cross' privacy policy. I authorize any medical practitioner, hospital, clinic, pharmacy and any British Columbia government health agency (including PharmaCare) or other medically related facility that has my health information to transfer the information to Pacific Blue Cross. This includes my health records and the health records of my covered dependents (if applicable), and details of coverage eligibility. A copy of our privacy policy is available by contacting Pacific Blue Cross. It is also available on our website at pac.bluecross.ca.

Applicant's signature	Applicant's full name (print)	Date (mm-dd-yyyy)
X	X	

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