MEDAVIE BLUE CROSS™

APPLICATION FOR INDIVIDUAL DENTAL PLAN

644 MAIN ST PO BOX 220 MONCTON NB E1C 8L3
230 BROWNLOW AVE DARTMOUTH PO BOX 2200 HALIFAX NS B3J 3C6
FOR ALL INQUIRIES: **1-800-667-4511**

Instructions
(1) All shaded areas are for Medavie Blue Cross use only.
(2) Print in ink.

PART I - BASIC INFORMATION

Applicant's Last Name		**Language Preference** ☐ English ☐ French	**Occupation**
Applicant's Address Street & No.		**COVERAGE** - Dental - 70% Reimbursement	
		Requested effective date of policy Please begin my coverage on the **1st day** of	
City/Town	Province / Postal Code	Month _____ Year _____.	
Applicant's Telephone No. (Home)	Applicant's Telephone No. (Business)	Please indicate your current Medavie Blue Cross coverage information (if applicable):	
E-mail Address		ID Number _____	
		Policy Number _____	

INDIVIDUAL REGISTRATION

First Name	Surname		Sex M/F	Date of Birth DD	MM	YY
Applicant		00				
Spouse / Cohabitant (as defined in policy)		01				
Children		02				
		03				
		04				

Are you and all listed dependents currently covered by a Provincial Health Plan in Atlantic Canada (Medicare in New Brunswick, Medical Services Insurance (MSI) in Nova Scotia, Hospital and Medical Services Ins. in Prince Edward Island or Medical Care Plan (MCP) in Newfoundland)?

☐ Yes ☐ No If no, please explain: _____

AGREEMENT

I, the undersigned, hereby apply for the benefits offered under the Individual Dental Plan from Medavie Blue Cross, as outlined in the Individual Dental Plan policy. I confirm that the information I have provided in this application is accurate and truthful.

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 Medavie 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 Medavie 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.

Your personal information will be securely stored using information systems owned or managed by Medavie Blue Cross, its agents and/or its service providers, both inside and outside of Canada. All service providers and agents are contractually bound to protect the confidentiality of all personal information.

I authorize Medavie Blue Cross to collect, use and disclose my personal information as described above.

Dated on this _____ day of _____ year _____.

Signature of Applicant _____ Signature of Spouse / Cohabitant (as defined in policy) _____

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 Medavie Blue Cross's privacy policies, visit medaviebc.ca or call 1-800-667-4511.

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I.D. No.: _____ CASH OFFICE: Amount Received: _____ ☐ Agent ☐ Branch ☐ Client

PLEASE COMPLETE THE PRE-AUTHORIZED DEBIT (PAD) PLAN AGREEMENT BELOW.

Payer Information - Please Print

Name of Payer: _____ Telephone Number: _____

Address: _____

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

Bank Account Information - Please Print

Please attach a void cheque or complete the section below.

Financial Institution: _____ Telephone Number: _____

Address: _____

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

FI Transit Number: |_|_|_|_|_| (branch - 5 digits; |_|_|_| FI - 3 digits) FI Account Number: |_|_|_|_|_|_|_|_|_|_|_|_|

Would you like your claim reimbursements automatically deposited in the same account? ☐ Yes ☐ No

Pre-Authorized Debit Details

Type of Service: ☐ Personal ☐ Business

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 pre-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/our right to cancel a PAD Agreement at my/our financial institution or by visiting www.payments.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.payments.ca.

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

FOR AGENT USE ONLY

I hereby certify that, as an agent for Medavie Blue Cross, I have informed the applicant of the importance of making full and accurate disclosure of the matters covered in this application and that any misrepresentations or omissions may give Medavie Blue Cross the right to cancel the contract of insurance and refuse coverage under the policy. I have disclosed the company or companies I represent and any conflicts of interest they may have with respect to this transaction and that I may receive a salary, commissions or other forms of compensation for the sale of insurance company products.

Agent's Name: Yanic Theriault (8571) Agent's Number: Yanic Theriault (8571)

Address: 19 Katherine Ave

City/Town: Moncton Province: NB Postal Code: E1C 7M7

Telephone Number: 506-852-8472 Fax Number: 506-852-8444

E-mail address: yanic.theriault@bluecountryinsurance.com

Agent's Signature: _____

Agent Comments: _____

MEDAVIE BLUE CROSS™

TEN DAY RIGHT TO EXAMINE POLICY

You have 10 days from the receipt of the policy to examine and return it for a full refund of money paid, if you are not entirely satisfied.