PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

BLUE® CHIP

MODULAR PLAN APPLICATION FOR GROUP BENEFITS

Please return this completed application with an initial deposit cheque to your Advisor and/or Pacific Blue Cross Account Executive

PART 1 — FOR OFFICE USE ONLY

Policy number	Effective date (mm-dd-yyyy)	Renewal date (mm-dd-yyyy)	Renewal notice period (Number of days)

PART 2 — PLAN SPONSOR INFORMATION

Legal company name	Operating name (if different than legal name)

Mailing address

Nature of business	Years in business	Number of eligible employees

PART 3 — DOCUMENTATION

Booklets and contracts are provided electronically (PDF format)

PART 4 — WAITING PERIOD

3 month waiting period – waive for current employees ☐ Yes ☐ No

PART 5 — CLASSES (GROUPS OF EMPLOYEES WITH THE SAME BENEFITS)

CLASS NUMBER	CLASS DESCRIPTION

PART 6 — DIVISION AND CONTACT

Division	Division name

Primary contact name	Title

Mailing address

Email	Phone number	Fax number

☐ All ☐ Billing ☐ Plan administrator ☐ ID cards ☐ Life & disability claims contact ☐ Signing authority

Division	Division name

Contact name	Title

Mailing address

Email	Phone number	Fax number

☐ All ☐ Billing ☐ Plan administrator ☐ ID cards ☐ Life & disability claims contact ☐ Signing authority

* ADMINnet update and reporting access will be granted to all persons identified in this section.

PART 7 — ADVISOR/RENEWAL CONTACT

First name	Last name

Agency name	Phone number	Fax number

Mailing address

☐ TPA (if applicable)	Email

PART 8 — FINANCIAL ARRANGEMENTS

Insured non-refund

BENEFITS	MODULE #	RATES	EMPLOYER CONTRIBUTION %
Basic Life			
AD&D			
Dependent Life			
Critical Illness			
LTD			
Health			
Dental			

PART 9 — DISABLED EMPLOYEES (Not eligible on the effective date)

FIRST NAME	LAST NAME	BIRTHDATE	SEX	LAST DAY WORKED	EXPECTED DATE OF RETURN	IS EMPLOYEE ON WAIVER OR PREMIUM WITH PREVIOUS CARRIER? If yes, list benefit(s) / volume(s) with previous carrier, and nature of disability.
		(mm-dd-yyyy)	☐ M ☐ F	(mm-dd-yyyy)	(mm-dd-yyyy)	
		(mm-dd-yyyy)	☐ M ☐ F	(mm-dd-yyyy)	(mm-dd-yyyy)	
		(mm-dd-yyyy)	☐ M ☐ F	(mm-dd-yyyy)	(mm-dd-yyyy)	
		(mm-dd-yyyy)	☐ M ☐ F	(mm-dd-yyyy)	(mm-dd-yyyy)	
		(mm-dd-yyyy)	☐ M ☐ F	(mm-dd-yyyy)	(mm-dd-yyyy)	

PART 10 — OTHER EMPLOYEES (Eligible but have not submitted a signed enrollment form because they are not at work)

FIRST NAME	LAST NAME	BIRTHDATE	SEX	LAST DAY WORKED	EXPECTED DATE OF RETURN	REASON THE EMPLOYEE IS NOT AT WORK
		(mm-dd-yyyy)	☐ M ☐ F	(mm-dd-yyyy)	(mm-dd-yyyy)	
		(mm-dd-yyyy)	☐ M ☐ F	(mm-dd-yyyy)	(mm-dd-yyyy)	
		(mm-dd-yyyy)	☐ M ☐ F	(mm-dd-yyyy)	(mm-dd-yyyy)	

PART 11 — AMOUNT PAID WITH APPLICATION

Total payment = $ ☐ **Please attach an initial deposit cheque for this amount**

PART 12 — DATA ACCESS AGREEMENT

1. This arrangement permits the plan sponsor to view and maintain Pacific Blue Cross (PBC) member and dependent coverage information through electronic systems or networks and software maintained and supported by PBC.
2. The data collected, used, disclosed and retained under this arrangement between PBC and the plan sponsor is consistent with the *Personal Information Protection Act* and other relevant privacy legislation.
3. PBC and the plan sponsor will maintain accurate, complete and current data in the electronic systems and networks used by them.
4. The plan sponsor will investigate all cases where it is suspected or is evident that there may be: (a) unauthorized access to or modification of data or services; (b) misuse of data or services; or (c) breaches of confidentiality. The plan sponsor will advise PBC immediately of any unauthorized access or use of data that may jeopardize the security of any computer system or network used to access data, or the confidentiality of data or the privacy of individuals.
5. PBC or the plan sponsor may terminate this data access arrangement with 90 days written notice.

PART 13 — STATEMENT

We agree that the statements recorded in this application are true and complete, to the best of our knowledge and belief, and shall form the basis of the group policy. Pacific Blue Cross reserves the right to retroactively audit claims and/or personal medical information after the first renewal period.

Authorized plan sponsor signature **X**	Full name and title (print)	Date (mm-dd-yyyy)

PRE-AUTHORIZED DEBIT (PAD)

To authorize PBC to debit your account and instruct your financial institution to make payments directly from your account:

Complete all sections, print and sign in ink.

Attach your blank cheque marked **"VOID"** here or complete the **Financial Institution Information** section below:

FINANCIAL INSTITUTION INFORMATION

Name of financial institution		Branch phone number (10 digits)
Branch address	City	Province
Transit number	Institution number	Account number

CLIENT CONSENT AND DECLARATION

I (we), the account holder(s), authorize PBC and the above-noted financial institution to debit my (our) account, at the above indicated branch, under terms and conditions agreed to by me (us) with PBC until such time as written notice to the contrary is given by me (us) to PBC.

The branch at which I (we) maintain the account is not required to verify that the payment(s) are drawn in accordance with this authorization.

A debit, in paper, electronic or other form, equal to the monthly balance owing for my benefits plan(s), may be drawn on my (our) account on the first day of each month, beginning (mm-dd-yyyy) _____. PBC will forward a statement of account in support of the debits to me (us) at least three days in advance of payment date, as pre-notification.

I (we) will notify PBC in writing of any changes in the account information or termination of this authorization prior to the next due date of the pre-authorized debit.

Items charged will be reimbursed subject to notification by me (us) to the branch of account within 90 days under any of the following conditions:

1. I (we) never provided the authorization to PBC.
2. The pre-authorization debit was not drawn in accordance with this authorization.
3. My (our) authorization was revoked.
4. The debit was posted to the wrong account due to invalid/incorrect account information supplied by the Payee.

I (we) understand that a written declaration to this effect must be given to my (our) financial institution.

I (we) acknowledge that delivery of this authorization to PBC constitutes delivery by me (us) to the above noted financial institution.

Signing officer's full name (print)	Date (mm-dd-yyyy)	Signing officer's full name (print)	Date (mm-dd-yyyy)
Authorized plan sponsor signature **X**	Full name and title (print)		Date (mm-dd-yyyy)