PO BOX 1046 WINNIPEG MB R3C 2X7
TEL: 204.775.0151 FAX 204.774.1761

DOCTORS MANITOBA
APPLICATION FOR VOLUNTARY HEALTH BENEFITS

THIS SECTION TO BE COMPLETED BY MEMBER

SURNAME	GIVEN NAME AND MIDDLE INITIAL(S)	MEMBER DATE OF BIRTH:	DAY	MONTH	YEAR

ADDRESS- STREET/BOX NUMBER	CITY OR TOWN	POSTAL CODE

TELEPHONE NUMBER HOME:	WORK:	GENDER ☐ MALE ☐ FEMALE	MANITOBA HEALTH NUMBER

PLEASE COMPLETE THIS SECTION IF YOU HAVE ELIGIBLE DEPENDENTS

☐ SPOUSE ☐ COMMON LAW	SURNAME (IF DIFFERENT THAN MEMBER'S)	GIVEN NAME AND MIDDLE INITIAL	DATE OF BIRTH DAY	MONTH	YEAR	GENDER ☐ MALE ☐ FEMALE

IF APPLICANT AND SPOUSE ARE NOT LEGALLY MARRIED PLEASE PROVIDE COMMENCEMENT DATE OF COHABITATION_____

UNMARRIED DEPENDENT CHILDREN:

SURNAME (IF DIFFERENT THAN MEMBER)	GIVEN NAME AND MIDDLE INITIAL	RELATIONSHIP	DATE OF BIRTH DAY	MONTH	YEAR	GENDER
						☐ M ☐ F
						☐ M ☐ F
						☐ M ☐ F
						☐ M ☐ F

COVERAGES APPLIED FOR

CHECK (√) THOSE PLANS YOU WISH	☑ AMBULANCE AND HOSPITAL	☑ EXTENDED HEALTH BENEFITS	☑ EMPLOYEE TRAVEL HEALTH PLAN

- **MEMBERS MUST ENROLL ACCORDING TO THEIR TRUE FAMILY STATUS**
- **ONCE ENROLLED, MEMBERS MAY NOT OPT OUT (EXCEPT IN THE EVENT OF DUPLICATE GROUP COVERAGE)**

DO YOU HAVE COVERAGE FOR ANY OF THE BENEFITS APPLIED FOR THROUGH ANOTHER INSURANCE PLAN? ☐ NO ☐ YES – **IF YES PLEASE INDICATE:**

BENEFITS COVERED ☐ HEALTH ☐ TRAVEL ☐ DRUGS	NAMES OF INSURED	NAME OF INSURANCE COMPANY	POLICY NUMBER

I CERTIFY THAT ALL THE ABOVE INFORMATION IS CORRECT AND I AGREE TO THE CONDITIONS OF THE GROUP AGREEMENT BETWEEN DOCTORS MANITOBA AND MANITOBA BLUE CROSS. I ALSO AGREE TO THE AUTHORIZATION AND CONSENT ON THE REVERSE SIDE OF THIS FORM.

MEMBER SIGNATURE:_____ DATE:_____

THIS SECTION IS TO BE COMPLETED BY DOCTORS MANITOBA

NAME OF GROUP **DOCTORS MANITOBA**	GROUP NUMBER	DATE OF HIRE DAY	MONTH	YEAR
		☐ FULL TIME		

MEMBER NUMBER	OCCUPATION	HOURS WORKED/WEEK	☐ PART TIME

I HEREBY CERTIFY THIS MEMBER MEETS THE CONTRACTUAL REQUIREMENTS OF BEING AN ELIGIBLE MEMBER	COMPLETED FOR DOCTORS MANITOBA BY	DATE	TELEPHONE

BLUE CROSS USE ONLY

GROUP NUMBER	**COVERAGE EFFECTIVE**			**CONTRACT NUMBER**
	DAY	**MONTH**	**YEAR**	

AUTHORIZATION AND CONSENT

I 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 may be collected, used, or disclosed to administer the terms of the group policy of which I am an eligible member, to develop and recommend suitable products and services to me, and to manage the Company'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 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 my policy or the group 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, if consent is withheld or revoked, the coverage may be denied or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding Blue Cross' privacy policies I can contact Blue Cross at 1.800.873.2583 or www.mb.bluecross.ca should I have questions as to the collection, use or disclosure of my personal information.

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