

**TO BE COMPLETED BY EMPLOYEE**

<p>51 Employee's Name</p> <p>Gender M/F</p> <p>Date of Birth</p>	<p>52 Address - City/Town</p> <p>Postal Code</p> <p>Phone Number</p>
<p><b>BASIC LIFE COVERAGE (Mandatory)</b></p> <p><input type="checkbox"/> Option 1 – <u>2x Annual Earnings</u> minimum \$16,000 maximum \$700,000</p> <p><input type="checkbox"/> Option 2 – <u>1x Annual Earnings</u> minimum \$8,000 maximum \$700,000</p>	<p>53 <b>Optional Life Coverage - Employee Only</b> Only those employees who elected Basic Life Option 1 may apply:</p> <p><input type="checkbox"/> Option 1 – <u>2 x Annual Earnings</u> Maximum \$300,000</p> <p><input type="checkbox"/> Option 2 – <u>1 x Annual Earnings</u> Maximum \$300,000</p> <p><input type="checkbox"/> I DO NOT wish to apply</p>

IF APPLICANT AND SPOUSE ARE NOT LEGALLY MARRIED PLEASE PROVIDE COMMENCEMENT DATE OF COHABITATION \_\_\_\_\_

If you have chosen YES to Family Life Coverage please complete this section:

**FAMILY COVERAGE**  
(The Employee is the beneficiary of the Insured spouse and children)

NO     YES

Name	Gender M/F	BIRTH DATE			Dependent Status
		DD	MM	YYYY	
Spouse					E - Student (College/University) S - Disabled
Children					

BENEFICIARY'S LAST NAME	FIRST NAME	INITIAL	RELATIONSHIP	PERCENTAGE
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____

Contingent Beneficiary – Applicable if the primary beneficiary (es) predeceases employee.

Beneficiary Last Name	First Name	Initial	Relationship	Percentage
_____	_____	_____	_____	_____

I certify the above information is true and correct and that all participants are eligible for coverage per the group agreement. I have read and understood the Authorization & Consent on the reverse side of this form and agree to the conditions of the group agreement between my employer and Manitoba Blue Cross. I hereby confirm the beneficiary designation and authorize payroll deductions if required.

Designate a trustee for minor beneficiary \_\_\_\_\_

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

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54 Name of Employer		Employer Number	Group Number	Employee Class - Life	Occupation
			41380		
• Date Employed	Total Yearly Coverage Amount	Completed for Employer by			
DD MM YYYY	\$ _____	Signature _____ Date _____			

**FOR BLUE CROSS USE ONLY**

Certificate Number	Group and Roll Number	Province	Status	Type of App.	Mode of Earnings	Occupation Code	Language
	41380		13	NA			
Employee Class - Life	Effective Date	NEXUS Code	Loading Factor		Ben. Code	DLIF Code	
	DD MM YYYY		W/CC	LTD			

Blue Cross Life Insurance Company of Canada underwrites all life and disability income benefits.

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## 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 Blue Cross may retain service providers inside and outside of Canada to assist them in their business and further understand that my personal information may be subject to disclosure to law enforcement and other authorities, where required by law, both inside and outside of Canada, when such information is in the possession of Blue Cross or one of its authorized service providers.

I understand that I have provided my consent for Blue Cross to collect, use and disclose my personal information as outlined in the Blue Cross Privacy Code. 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 Manitoba Blue Cross's privacy policies I can contact Manitoba Blue Cross at 204.775.0151 or 1.800.873.2583 or [mb.bluecross.ca](http://mb.bluecross.ca) should I have questions as to the collection, use or disclosure of my personal information.

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