PACIFIC BLUE CROSS™ BC Life®

DO NOT WRITE IN THIS SPACE

WAIVER OF GROUP BENEFITS

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | Fax: 604 419-2149 | enrollment@pac.bluecross.ca

MEMBERS — Please complete BLACK portions of this application.
EMPLOYERS/PLAN ADMINISTRATORS — Please complete RED portion of this application.

PART 1 — MEMBER INFORMATION

Policy number	Benefit plan to be changed ☐ Dental ☐ Extended Health ☐ BC Life ☐ Other: ______	ID number

First name	Last name	Middle initial

Name of company/organization

PART 2 — WAIVER OF GROUP BENEFITS: Complete this section if waiving benefits

The Pacific Blue Cross Extended Health Care (EHC) plan is not the same as coverage under a government health/medical plan in any province or territory. If another plan covers you/your dependent(s) for EHC or Dental benefits, you may waive such benefits under this plan. Before you sign this form, read your employee booklet or ask your employer to explain the benefits to you. You should fully understand all the benefits and plan rules.

SECTION A — Waiver certified by employer

I do not want coverage for the following: ☐ Extended Health Care ☐ Dental Care ☐ For myself and my dependents ☐ Dependents only

I do not want coverage for the following BC Life benefits: ☐ Group term life ☐ Accidental death & dismemberment ☐ Short-term disability ☐ Long-term disability ☐ Dependent life ☐ Critical illness

EMPLOYER/PLAN ADMINISTRATOR — I hereby certify that: minimum participation requirements, as stipulated in the contract, have been met; this plan requires members/employers to contribute to the cost of coverage; benefit coverage is not a condition of employment.

Employer/Plan administrator's signature X	Date (mm-dd-yyyy)

SECTION B — Waiver due to coverage under another plan

I choose to waive the benefit(s) below because I am covered by another plan:
☐ Extended Health Care ☐ Dental care ☐ For myself and my dependents ☐ Dependents only

If the other plan terminates, I understand that there may be time limits for applying for coverage under this Pacific Blue Cross plan. If I apply late, or if I apply while the other plan is still active, I understand that dental coverage may be restricted to $250 per person for the first year, and/or my dependents and I will have to provide evidence of good health, and Pacific Blue Cross may decline to cover me or my dependents.

Employee signature is required for SECTIONS A and B

I have been offered the opportunity to participate in my employer's benefits plan. I have carefully studied the benefits and the plan rules, and I understand that if I apply at a later date for any benefit(s) that I am now waiving, as explained above, dental coverage may be restricted to $250 per person for the first year of coverage, and/or I will be required to prove, at my own expense, that I and my dependents are in good health. Pacific Blue Cross and/or BC Life reserve the right to refuse my application if my health or my dependents' health is not considered satisfactory. The privacy policy is available from your employer/plan administrator, online at www.pac.bluecross.ca or by calling Pacific Blue Cross/BC Life at 604 419-2000.

Employee's signature X	Date (mm-dd-yyyy)

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MAIL YOUR WAIVER
Pacific Blue Cross
PO Box 7000, Vancouver, BC V6B 4E1

DROP IT OFF
4250 Canada Way
Burnaby, BC V5G 4W6

FAX IT
604 419-2149

EMAIL IT
enrollment@pac.bluecross.ca

www.pac.bluecross.ca