WAIVER OF GROUP BENEFITS

PACIFIC BLUE CROSS™

BC Life®

for PBC office use only

Mailing Address:
PO Box 7000,Vancouver, BC V6B 4E1
Street Address:
4250 Canada Way , Burnaby, BC
Fax: 604 419-2990

Group Number(s) of Plans to be Waived

Dental Care	Extended Health	BC Life

Surname	First Name	Middle Initial	ID Number (e.g. S.I.N.)

Name of Company/Organization	Birth Date (mm/dd/yy)	Date Employed (mm/dd/yy)

The Pacific Blue Cross (PBC) 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 dependents for Extended Health Care or Dental Care Benefits, you may waive such benefits under this plan. In order to waive benefits for any other reason, your employer must first ensure that a certain percentage of all eligible employees participates in this group plan. Before you sign this form, please read an employee booklet or ask your employer to explain benefits to you; you should fully understand all the benefits and plan rules.

Section A - Waiver due to coverage under another plan

I elect to waive the benefit(s) checked below due to similar coverage under another plan:

❑ Extended Health Care ❑ Dental Care ❑ For myself and my dependent ❑ For my dependents only

Details of other plan: _____ Group Policy Number _____ Identity Number with _____ Name of Insurance Company

If the other plan terminates, I understand that there may be time limits for applying for coverage under this PBC 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 PBC may decline to cover me or my dependents.

Section B - Waiver under this section must be certified by employer

I do not want coverage for the PBC Benefit(s) checked below:

❑ Extended Health Care ❑ Dental Care ❑ For myself and my dependent ❑ For my dependents only

I do not want coverage for the following BC Life Benefit(s) checked below:

❑ Group Term Life ❑ Accidental Death and Dismemberment ❑ Dependent Life ❑ Critical Illness

❑ Short Term Disability ❑ Long Term Disability

Employer certification for Section B

I hereby certify that the following conditions of waiver, which apply to Section B above, have been satisfied:

1) Minimum participation requirements (as stipulated in the contract/policy) have been met

2) This plan requires members/employees to contribute to the cost of coverage

3) That benefit coverage is not a condition of employment.

X _____ Signature of Employer _____ Date

Employee signature

I have been offered the opportunity to participate in my employer's group benefits plan under the above group number(s). 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 under Section B, or Section A 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 my health or my dependents' health is good. PBC and/or BC Life reserves the right to refuse my application if my health or my dependents' health is not considered satisfactory. I consent to the personal information provided above being retained, used and disclosed in accordance with Pacific Blue Cross/BC Life's privacy policy.
Note: A copy of the Privacy Policy is available by contacting Pacific Blue Cross/BC Life. It is also available on our Web site at www.pac.bluecross.ca or from your employer.

X _____ Signature of Employee _____ Date

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