Manitoba
Association of
Retired
Government
Employees

APPLICATION FOR EXTENDED HEALTH CARE, DENTAL, AND PRESTIGE TRAVEL/TRIP CANCELLATION PLANS

If you have any questions about the Plan, or need assistance completing your application form, please contact the Plan Administrator, Johnson Insurance, at 1.877.989.2600 (Option #2) or via email at pbservicewest@johnson.ca.

1. APPLICATION INFORMATION – PLEASE PRINT CLEARLY

First Name(s)	Last Name		Gender	
			☐ Male	☐ Female
Address (including Apartment/Unit Number)				
City/Town	Province/Territory	Postal Code	Telephone Number ( )	
Date of Birth (DAY / MONTH / YEAR)	Provincial Registration #		Personal Health ID #	Email Address

I am a member of MARGE: ☐ Yes ☐ No **If no, please complete the form on the MARGE website: www.mbgovretirees.ca**

2. PLAN INFORMATION

EXTENDED HEALTH CARE (EHC) PLAN:

I wish to enrol in the EHC Plan	☐ No ☐ Basic ☐ Enhanced	Indicate status of coverage required	☐ Single ☐ Couple ☐ Family

Are you enrolled in your Province's Pharmacare Plan*? (Applicable to Provinces/Territories where a Pharmacare Program exists.)

☐ Yes ☐ No

***If no, please contact your Province's Pharmacare to enroll in their program as it is a requirement for the MARGE Plan.**

PRESTIGE TRAVEL PLAN (only available with EHC):

I wish to enroll in the Travel Plan ☐ Yes ☐ No

NOTE: You must enrol in the EHC Plan to elect Travel Plan coverage.

DENTAL PLAN (only available with EHC):

I wish to enrol in the Dental Plan
- ☐ No
- ☐ Basic (80% Basic/Preventative; 80% Minor Restorative)
- ☐ Enhanced (85% Basic/Preventative; 85% Minor Restorative; 60% Major Restorative)

Indicate status of coverage required:
- ☐ Single
- ☐ Couple
- ☐ Family

Check here if you are maintaining coverage in addition to this Plan: ☐

Are you the: ☐ Member OR ☐ Spouse

NOTE: Coverage for this Plan will become effective the 1st day of the month following the date of receipt of this form.

Insurance Company ______________________________ **Policy Number** ______________________________

If you are not maintaining additional coverage, when transferring from an employer sponsored group insurance plan or your spouse's employer sponsored group insurance plan, you must provide the termination date (in space below). Coverage for this Plan is effective the day after your or your spouse's plan terminates.

Termination Date of Your or Your Spouse's group benefits plan:	DAY	MONTH	YEAR

NOTE: Those with current group benefits coverage may apply within 60 days of losing existing employer coverage. After 60 days of prior plan termination, evidence of insurability is required.

IMPORTANT – YOU MUST COMPLETE AND SIGN SECTION 4 ON THE REVERSE FOR COVERAGE TO BE IN FORCE

If you have selected Couple or Family coverage, please provide Spousal/Dependent Details below:

First Name(s)		**Last Name**		**Gender** ☐ **Male** ☐ **Female**
Provincial Health Registration #	**Personal Health ID #**	**Date of Birth** DAY MONTH YEAR		**Dependents age 21+** ☐ Full Time Student ☐ Disabled
First Name(s)		**Last Name**		**Gender** ☐ **Male** ☐ **Female**
Provincial Health Registration #	**Personal Health ID #**	**Date of Birth** DAY MONTH YEAR		**Dependents age 21+** ☐ Full Time Student ☐ Disabled
For additional Dependents, please provide information on a separate page.				

3. MONTHLY PREMIUMS PAYMENT

☐ **Automatic Bank Withdrawal.** I have enclosed a **sample cheque marked "VOID"**. I authorize Johnson Insurance, the Plan Administrator, to make monthly deductions (including mid-term adjustments and arrears) from the bank, trust company or credit union account shown on the cheque. Deductions are withdrawn one month in advance, for example, the August 5th deduction pays for September coverage.

4. CONSENT AND SIGNATURE

I hereby certify that I am a Member in good standing with the Manitoba Association of Retired Government Employees and my eligibility ceases upon termination of my MARGE membership.

I authorize that my premium for this insurance, including any mid policy year adjustments, arrears and renewals, be deducted in monthly amounts due on or after this date of application. I understand that my policy will be automatically cancelled should Johnson Insurance receive two or more Non-Sufficient Funds (NSF) notices on my account.

I recognize that the MARGE EHC Plans require members to be enrolled in their Provincial Pharmacare Program. If you are not already enrolled in your Province's Pharmacare Program, please contact Pharmacare as soon as possible.

I understand that EHC and Dental coverage will begin on the day after my current group benefits terminate OR, if maintaining coverage under my current group plan, on the 1st of the month following the date of receipt of application. If applying as a late applicant, I understand EHC coverage will become effective the date the completed application is approved by the Insurer.

I also understand that unless I advise Johnson Insurance in writing to the contrary, the coverage I have selected **will remain in effect for each policy year thereafter.** Johnson Insurance will provide me with notification of my renewal before the beginning of each subsequent policy year, which is May 1st.

I authorize my "Group", the Manitoba Association of Retired Government Employees, my "Plan Administrator" Johnson Insurance, and my "Insurer" Desjardins Financial Security (collectively, the "Providers") to collect, use, maintain and disclose my financial, medical and other personal information, including the information relating to any spouse or dependent who may be the subject of this application (the "Information"), for the purposes of the Extended Health Care and/or Dental Plans (the "Plans") administration and audit and the assessment, investigation, management, processing and/or underwriting of this application and any claims under the Plans (collectively, the "Purposes"). **I authorize** any person with information, including any medical and health professional, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer investigative agency and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with the Providers and any replacement Plan Administrator, Insurer, Administrator approved by my Group, for the Purposes. **I understand** that any coverage will not become effective until approved by the Providers. **I authorize** the use of my Provincial health number and any Group member ID for the purposes of identification and administration.

Signature of Applicant **Date**

Signature of Spouse (if Couple or Family coverage selected)

PLEASE FORWARD YOUR APPLICATION TO:

JOHNSON INSURANCE
GROUP BENEFITS
#100, 17203 – 103 Avenue NW
Edmonton, Alberta T5S 1J4
Fax: (780) 420-6082