

Application for Extended Health Care, Dental, and Journey Travel Plans

If you have any questions about the plan, need assistance completing your application form, or need to submit written notice of change or cancellation please contact the plan administrator, belairdirect at 1 833 749.1324

1. Application Information – please print clearly

First name	Last name	Gender	
Address (including apartment/unit #)		Telephone #	
City/Town	Province/Territory	Postal code	Email address
Date of birth (dd/mm/yyyy)	Provincial health #	Fair pharmacare registration #	

These insurances are only available to MARGE members. If you are not a MARGE member, please visit the MARGE website: mbgovretirees.ca

2. Plan information

Extended health care (EHC) plan

I wish to enrol in the EHC Plan Indicate status of coverage required Single Couple Family

I am enrolled in a pharmacare plan Yes No

Please note, if your province or territory of residence has pharmacare plan, these insurance coverages are only available if you are enrolled in the pharmacare plan.

Journey travel plan (only available with EHC)

I wish to enrol in Journey travel plan 62-day base plan 93-day base plan

This insurance provides an unlimited number of trips within Canada of any duration, and an unlimited number of trips outside Canada of up to 62 or 93 day consecutive days, depending on your base plan selection.

Deductible option (select one)

No deductible \$1,000 deductible (save 10% on base plan premiums)

Your deductible option can only be changed at the start of each new policy, May 1st.

Note - you must enrol in the EHC Plan to choose Journey travel plan. Your coverage option (single, couple or family) under Journey travel plan will match the status of coverage selected under the EHC plan.

To be eligible for insurance under Journey Travel Insurance, you must:

- Be a member, or a spouse or dependent of a member.
- Be a Canadian resident.
- Be insured under your Provincial or Territorial Health Insurance Plan; and
- Be enrolled for the MARGE extended health care plan.

A dependent may be covered under couple or family coverage but cannot apply for coverage under this insurance individually.

I confirm that all persons listed in this application are eligible for Journey travel plan.

Dental plan

I wish to enrol in the dental plan No Basic (80% basic/preventative, 80% minor restorative) Enhanced* (80 basic/preventative, 80% minor restorative, 50% major restorative)

Indicate status of coverage required Single Couple Family

Check here if you are maintaining other existing EHC coverage in addition to this plan*: Are you the Member Or Spouse

Insurance company: _____ Policy #: _____

Note – if maintaining other existing EHC plan, coverage under the selected plan(s) will commence on the 1st day of the month following the date this application is received.

If you are not maintaining additional EHC 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 (dd/mm/yyyy) *:			
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Note - those with existing group EHC benefits must 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	Last name	Gender
Provincial health #	Date of birth (dd/mm/yyyy)	Dependents age 21+ <input type="checkbox"/> Full Time Student aged 24 or less <input type="checkbox"/> Disabled
First name	Last name	Gender
Provincial health #	Date of birth (dd/mm/yyyy)	Dependents age 21+ <input type="checkbox"/> Full Time Student aged 24 or less <input type="checkbox"/> Disabled

For additional dependents, please provide information on a separate page.

3. Monthly premium payment

Automatic bank withdrawal. I authorize belairdirect., 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. Due to application processing time, and the effective date of coverage, the initial deduction may cover up to 3 months of premium. I understand that my policy will be automatically cancelled should belairdirect receive two or more Non-Sufficient Funds (NSF) notices on my account.

Claim payment direct deposit. I authorize belairdirect to deposit my Extended Health Care (EHC) and dental claims reimbursements directly into my bank account.

I have enclosed a **sample cheque** marked "VOID" to be used for automatic bank withdrawals and claims reimbursements.

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

I also understand that unless I advise belairdirect Agency Inc. in writing to the contrary, the coverage I have selected will remain in effect for each policy year thereafter. belairdirect Agency Inc. will provide me with notification 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" belairdirect Agency Inc., my "Insurers" the Desjardins Financial Security and Belair Insurance Company Inc. (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 Plan, Dental Plan and/or Journey Travel Insurance (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. For further information on how Belair Insurance Company Inc. and belairdirect Agency Inc. manage your personal information, please visit: belairdirect.com/en/privacy.

Signature of applicant

Date

Signature of spouse (if couple or family coverage selected)

Date

Please forward application to: belairdirect
Group benefits administration
PO Box 4005 Stn A
Toronto, ON M5W 0M7