NOVA SCOTIA
Public Service Commission

Application for Employee Group Health Benefits – Province of Nova Scotia

Single Coverage is mandatory unless employee provides proof of comparable coverage.

Send completed form to Benefits@novascotia.ca or Benefits Unit PO Box 943 Halifax NS B3J 2V9 or Fax 902-424-0756

Section 1: Employee Information

Coverage Applied for:	Single		Family		Employee ID	
Last Name	First Name			Initial		
Address	City/Town			Province	Postal Code	
Phone Number	Date of Birth (DD/MM/YYYY)				Gender	

Section 2: Eligible Dependents

Spouse Last Name	Spouse First Name	Initial	Gender	Date of Birth DD/MM/YYYY	Date of Cohabitation if Common Law
Child Last Name	**Child First Name**	**Initial**	**Gender**	**Date of Birth**	**Status***

(*) Dependent Status:
Student - If dependent child is over age 21 and attending an accredited school, college or university an Overage Dependent Form is required Disabled - if the dependent child is physically or mentally disabled (Medavie Blue Cross approval required)
Child - natural, adopted, stepchildren, or the child over whom the member or spouse has been appointed as legal guardian with parental authority. For those other than natural or stepchildren, legal documents must be provided and approval is required.

Section 3: Coordination of Benefits – complete if you or your dependents have coverage under any other insurer

Name of Other Insurer	Effective date of coverage
Identification/Certificate Number	Policy Number
Name of Cardholder	Date of Birth (DD/MM/YYYY)

Indicate S for Single coverage or F for Family coverage where applicable

All:	Hospital:	Extended Health:	Vision:	Drugs:	Dental:

Section 4: Declaration and Authorization

I understand that the personal information provided herein, as well as any other personal information currently held or collected in the future by Medavie Blue Cross may be collected, used or disclosed to administer the terms of my policy or the group policy of which I am eligible member, to recommend suitable products and services to me, and to manage Blue Cross' 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 organizations, health care professionals or institutions, life and health insurers, government and regulatory authorities and other third parties when required to administer and manage the benefits outlined in the policy of which I am an eligible member. I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time, however, in some instances doing so may prevent Blue Cross from providing me with the requested coverage or benefits. I understand why my personal information is needed and I am aware of the risks and benefits consenting or refusing to consent to its disclosure. I certify that all information contained herein is correct and hereby authorize payroll deductions, if required. If applying for benefits for my spouse and/or dependents, I certify that I am authorized to release information concerning my spouse and/or dependents, for the purposes of administering and managing the benefit plan. A photocopy of this authorization shall be valid as the original. The consent complies with federal and provincial privacy laws. For additional information regarding privacy policies at Medavie Blue Cross, visit www.medaviebc.ca or call 1-800-667-4511.

Employee Signature	Date (DD/MM/YYYY)