



PO BOX 1046 STN MAIN WINNIPEG MB R3C 2X7
 TEL 204.775.0151 Fax 204.772.1231

**ROLLING RIVER SCHOOL DIVISION
 NON-TEACHING EMPLOYEES**

EMPLOYEE ASSISTANCE PLAN

THIS SECTION TO BE COMPLETED BY EMPLOYEE

LAST NAME		FIRST NAME		EMPLOYEE DATE OF BIRTH	DD	MM	YYYY
MAILING ADDRESS - STREET/BOX NUMBER			CITY OR TOWN	PROVINCE	POSTAL CODE		
PHONE NUMBER HOME		WORK		EMAIL ADDRESS	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		PROVINCIAL HEALTH NUMBER? <input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> UNDISCLOSED <input type="checkbox"/> OTHER			

PLEASE COMPLETE THIS SECTION IF YOU HAVE ELIGIBLE DEPENDENTS

<input type="checkbox"/> MARRIED	LAST NAME (if different than employee's)	FIRST NAME	DATE OF BIRTH			GENDER	
<input type="checkbox"/> COMMON LAW			DD	MM	YYYY	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> UNDISCLOSED <input type="checkbox"/> OTHER

IF APPLICANT AND SPOUSE ARE NOT LEGALLY MARRIED PLEASE PROVIDE COMMENCEMENT DATE OF COHABITATION (DD/MM/YYYY) _____

UNMARRIED DEPENDENT CHILDREN:

LAST NAME (if different than employee's)	FIRST NAME	RELATIONSHIP	DATE OF BIRTH			GENDER
			DD	MM	YYYY	
						<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNDISCLOSED <input type="checkbox"/> OTHER
						<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNDISCLOSED <input type="checkbox"/> OTHER
						<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNDISCLOSED <input type="checkbox"/> OTHER
						<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNDISCLOSED <input type="checkbox"/> OTHER

COVERAGE APPLIED FOR

CHECK (✓) WHICH PLAN YOU WISH **EMPLOYEE ASSISTANCE PLAN**

• **EMPLOYEES MUST ENROLL ACCORDING TO THEIR TRUE FAMILY STATUS.**

I certify the above information is true and correct and that all participants are eligible for coverage per the group agreement. I have read and understood the Authorization & Consent on the reverse side of this form and agree to the conditions of the group agreement between my employer and Manitoba Blue Cross. I authorize payroll deductions if required.

EMPLOYEE SIGNATURE _____ DATE _____

THIS SECTION TO BE COMPLETED BY EMPLOYER

NAME OF DIVISION ROLLING RIVER SCHOOL DIVISION		GROUP AND ROLL NUMBER 8058		DATE OF HIRE	DD	MM	YYYY
EMPLOYEE NUMBER	OCCUPATION	HOURS WORKED/WEEK		<input type="checkbox"/> FULL TIME			
				<input type="checkbox"/> PART TIME			
I HEREBY CERTIFY THIS EMPLOYEE MEETS THE CONTRACTUAL REQUIREMENTS OF BEING AN ELIGIBLE EMPLOYEE			COMPLETED FOR EMPLOYER BY	DATE (DD/MM/YYYY)		TELEPHONE	

BLUE CROSS USE ONLY

GROUP NUMBER 8058	ROLL	COVERAGE EFFECTIVE (DD/MM/YYYY)	CERTIFICATE NUMBER
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AUTHORIZATION AND CONSENT

I understand that the personal information provided herein as well as any other personal information currently held or collected in the future by Manitoba Blue Cross may be collected, used, or disclosed to administer the terms of the group policy of which I am an eligible member, to develop and recommend suitable products and services to me, and to manage the company's 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 Plans, health care professionals or institutions, health and life insurers, government and regulatory authorities, and other third parties when required to administer the benefits outlined in my policy or the group policy of which I am an eligible member. I understand that Manitoba Blue Cross may retain service providers inside and outside of Canada to assist them in their business and further understand that my personal information may be subject to disclosure to law enforcement and other authorities, where required by law, both inside and outside of Canada, when such information is in the possession of Manitoba Blue Cross or one of its authorized service providers.

I understand that I have provided my consent for Manitoba Blue Cross to collect, use and disclose my personal information as outlined in the Manitoba Blue Cross Privacy Code. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, the coverage may be denied or rescinded.

I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding Manitoba Blue Cross's privacy policies or for questions as to the collection, use or disclosure of my personal information, I can contact Manitoba Blue Cross at 204.775.0151 or 1.800.873.2583 or mb.bluecross.ca.

I authorize Manitoba Blue Cross to collect, use and disclose my personal information as described above.

