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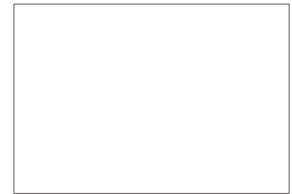

HEB Manitoba
HEALTHCARE EMPLOYEE BENEFIT PLANS

Retiree Healthcare Plan

Change Form

Please complete this form if you would like to temporarily waive participation because you have alternate coverage under another approved healthcare plan, or to make a change in the HEB Manitoba Retiree Healthcare Plan or are rejoining the plan after your alternate coverage has ceased. You must notify us of your alternate coverage or coverage end **within 60 days** of attaining or losing it, to be eligible to temporarily waive or be eligible to rejoin the retiree health care plan. If you have any questions, contact us at phone: (204) 942-6591 or toll-free: 1-888-842-4233.

Section 1: Retiree Information Required

Retiree Name: ______________________ ______________________ ______________________
Last name First name Middle initial

Mailing Address: ______________________ ______________________ ____________ ____________
City/Town Province Postal code

Birth Date: ________ | ________ | ________ ❑ Male ❑ Female Email: ______________________
DD MMM YYYY

Employee SIN: ______________________ HEB ID#: ______________________
For identification purposes

Section 2: Type of Change

Please select all changes that apply and complete the required section(s).

❑ Name Change (complete part A)

❑ Marital status/dependants information change (complete parts A & B & C)

❑ Loss of alternate group plan coverage: re-enrol (complete part A & B & D)

❑ Acquired alternate group plan: temporarily waive (complete parts C & D)

Note: If you are adding a spouse/common-law partner and/or adding or deleting dependant children, you must also complete part A and part B. If this change results in a change to your coverage level (i.e. single or family) you must also complete part C.

A. Change in Marital Status/Dependant Information

Please select all changes that apply and complete the required section(s).

Reason for change:

❑ Married/common-law (complete part A, B & C)

❑ Separated/end of common-law relationship (complete part A, B & C)

❑ Death of spouse/common-law partner (complete part A & C)

❑ Change in dependant (complete part A, B & C)

❑ Change of Legal Name (complete part A)
Proof of name change is required. For example, a copy of a birth certificate, passport, marriage certificate, or license.

Former Name: ______________________

New Name: ______________________

Effective Date: ________ | ________ | ________
DD MMM YYYY

B. Eligible Family Member Information

Spouse/Common-law Information

Your spouse is defined as the person who is legally married to you. In the case of separation, the former spouse is no longer eligible for coverage. You must declare your spouse within 60 days of the date of marriage, otherwise restrictions will apply. Your common-law partner is defined as the person who has continuously resided with you for at least one full year, and whom you have represented as your conjugal partner. You must declare your common-law partner within 60 days of the date you **begin** living together (Date of Cohabitation), otherwise restrictions will apply. You are required to change your coverage from single to family, although he or she will not be eligible for coverage until you have lived together for one year. The date of coverage for your common-law partner will be the first of the month following the one-year anniversary of cohabitation.

Note: Unless you have other eligible family members, you will pay premiums for single coverage until your partner becomes eligible for coverage.

Spouse's Name: ______________________ ______________________ ______________________
Last name First name Middle initial

❑ Male ❑ Female

❑ Does not reside in Canada

Birth Date: ______ | ______ | ______ Date of Marriage: ______ | ______ | ______ Date of Cohabitation: ______ | ______ | ______
DD MMM YYYY DD MMM YYYY DD MMM YYYY

Dependent Information

Please see the Retiree Healthcare Brochure for information on eligible family members.

Last Name	First Name	Disabled	Male	Female	Birth Date			Add	Remove	Does Not Reside in Canada
					DD	MMM	YYYY			
		❑	❑	❑				❑	❑	❑
		❑	❑	❑				❑	❑	❑
		❑	❑	❑				❑	❑	❑

C. Change in Coverage

❑ No change required ❑ Change required (please select the new election that applies)

Changes to coverage must be made within 60 days of the event. e.g., marriage, separation, start or end of a common-law relationship, death, birth, adoption (legal documentation required), or if you have acquired or lost alternate group coverage. Changes to coverage made after 60 days of the event, will result in coverage restrictions. You must enrol in family coverage if you have a spouse/common-law partner and/or dependant children. Employees who have permanently opted-out of the Retiree Healthcare Plan are not eligible to join this Plan again in future under any circumstances.

❑ **I certify that I have declared my true family status (required)**

Current Coverage:	❑ Single Healthcare coverage	❑ Family Healthcare coverage	❑ Waived Healthcare due to coverage under an alternate group plan (Section D)
New Election:	❑ Single Healthcare coverage	❑ Family Healthcare coverage	❑ Waived Healthcare due to coverage under an alternate group plan (Section D)

D. Acquired/Lost Coverage Under Alternate Group Plan(s)

Please select all changes that apply and complete the required section(s).

You must notify HEB Manitoba within 60 days of acquiring or losing coverage under an alternate group plan in order to waive coverage or join the HEB Manitoba Retiree Healthcare Plan without restrictions. You must provide the name of the group healthcare coverage provider and plan number below.

Option 1: ❑ I have acquired alternate group healthcare coverage and am temporarily waiving participation in the HEB Manitoba Retiree Healthcare Plan

Temporary Waiver (Complete if you have attained alternate coverage and wish to temporarily waive participation in the plan)

❑ I understand the terms and conditions of the HEB Manitoba Retiree Healthcare Plan being offered to me, but I decline participation at this time because I am insured under an alternate healthcare plan. I understand that if I lose my coverage under the alternate plan, I **must** apply for coverage under the HEB Manitoba Plan within 60 days of the date of loss of coverage or I will lose my eligibility to re-enrol. I want to temporarily waive participation in the HEB Manitoba Retiree Healthcare Plan. (Please note that Social Assistance and Manitoba Pharmacare are not considered alternate coverage in which you may temporarily waive under.) Please provide the alternate healthcare plan information below.

Option 2: ❑ I have lost my coverage under an alternate group healthcare plan and want to re-enrol in the HEB Manitoba Retiree Healthcare Plan

Alternate Healthcare Coverage Provider: ______________________________ Plan Number: ____________________

Effective Date of Acquiring Alternate Coverage: ______ | ______ | ______ (DD MMM YYYY) Effective Date of Loss of Alternate Coverage: ______ | ______ | ______ (DD MMM YYYY)

Retiree Signature: ______________________________ (Required) Date Signed: ______ | ______ | ______ (DD MMM YYYY)

Section 3: Retiree Consent and Authorization Required

Premium Payment Authorization

Premiums for the Retiree Healthcare Plan are automatically deducted from your monthly Healthcare Employees' Pension Plan (HEPP) payment at retirement which may include premiums deducted retroactively, if applicable. If you do not have a pension under HEPP, or if your monthly pension amount is less than your monthly Retiree Healthcare Plan premiums, you must provide **either a void cheque or your banking/financial information** so that premiums can be automatically deducted from your banking or financial institution account.

Should premiums need to be deducted from my banking or financial institution account, I authorize HEB Manitoba to deduct the balance of premiums from my account.

General Authorization

It is understood and agreed that:

1. The statements on this application are complete, true and correctly recorded and no representations are made to induce the insurance of, and as part of the consideration for the coverage herein applied for;
2. The coverage will be effective only if this application is accepted by Manitoba Blue Cross and such coverage shall not be effective prior to the effective date as established by Manitoba Blue Cross;
3. The coverage applied for is that described in the Master Group Agreement held by the Healthcare Employees' Benefits Plan (HEBP);
4. Retirees must enrol according to their true family status, listing all eligible dependents;
5. In order to protect the viability of these plans, retirees enrolled in supplementary health plans are not permitted to opt-out (except in the event of recently obtained duplicate coverage).

I authorize HEB Manitoba to deduct the required premiums from my monthly pension and/or my banking/financial institution account for payment to Manitoba Blue Cross.

HEB Manitoba Consent

I understand and agree:

- That my personal information and personal health information may be collected, used and disclosed by representatives of HEB Manitoba for the purpose of assisting Manitoba Blue Cross and/or Blue Cross Life Insurance Company (Blue Cross) with the administration of the Retiree Group Healthcare Plan, including matters related to any benefits payable to me under the terms of my policy or the group policy of which I am an eligible member
- That personal information and personal health information may be collected, used and disclosed by representatives of HEB Manitoba for the purpose of conducting periodic audits of Blue Cross or other third parties involved in the administration of the Retiree Group Healthcare Plan; and
- That my privacy and the confidentiality of the personal information and personal health information collected, used and disclosed by representatives of HEB Manitoba for the purpose of assisting Blue Cross with the administration of the Retiree Group Healthcare Plan, will be protected in accordance with the relevant privacy policies and privacy law(s).

I authorize representatives of HEB Manitoba to:

- Collect, use and disclose to Manitoba Blue Cross and to each other, my personal information and personal health information, for the identified purposes.
- Exchange and disclose personal information with other individuals and organizations acting on behalf of HEB Manitoba Benefit Plans to administer any potential benefit entitlements.

Please direct **privacy-related** questions, comments or requests to:

Corporate Privacy Officer
HEB Manitoba
900-200 Graham Avenue
Winnipeg, MB R3C 4L5

Phone: (204) 975-3197
Toll-free: 1-855-975-3197 (outside Winnipeg)
Fax: (204) 943-3862
Email: privacy@hebmanitoba.ca

Manitoba Blue Cross 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, healthcare 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 my personal information will be kept confidential and secure. 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 I can contact Manitoba Blue Cross at 1-800-873-2583 or www.mb.bluecross.ca should I have questions as to the collection, use or disclosure of my personal information.

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

I certify that I have read and understood the above Authorizations, HEB Manitoba and Manitoba Blue Cross Consents and agree to the contents therein.

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.

Retiree Signature: ______________________________ Date Signed: ________ | ________ | ________
DD MMM YYYY

Retiree Name: ______________________________
Please print

Form Return

Please submit signed, dated, and completed form to HEB Manitoba, 900-200 Graham Avenue, Winnipeg MB R3C 4L5.