Manitoba Association of Retired Government Employees

APPLICATION FOR EXTENDED HEALTH CARE, DENTAL, AND PRESTIGE TRAVEL INSURANCE PLANS

If you have any questions about the Plan, or need assistance completing your application form, please contact the Plan Administrator, Johnson Inc., 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	Date of Birth DD MM YYYY
Address (including Apartment/Unit Number)			
City/Town	Province/Territory	Postal Code	Telephone Number ( )
Provincial Registration #	Personal Health ID #	Email Address	

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

2. PLAN INFORMATION

EXTENDED HEALTH CARE (EHC) PLAN:

I wish to enrol in the EHC Plan	☐ Basic ☐ Enhanced	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 a Pharmacare Plan, these insurance coverages are only available if you are enrolled in the Pharmacare Plan.	

PRESTIGE TRAVEL INSURANCE (only available with EHC):

I wish to enrol in Prestige Travel Insurance	☐ 62-day Base Plan ☐ 93-day Base Plan	This insurance provides an unlimited number of trips within Canada of any duration and unlimited number of trips outside Canada of up to 62 or 93 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 year, May 1st.	

NOTE: You must enrol in the EHC Plan to choose Prestige Travel Insurance. Your coverage option (Single, Couple or Family) under Prestige Travel Insurance will match the status of coverage selected under the EHC Plan.

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

a) be a member, or a spouse or dependent of a member;
b) be a Canadian resident;
c) be insured under your Provincial or Territorial Health Insurance Plan; and
d) 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 Prestige Travel Insurance.

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 other existing EHC coverage in addition to this Plan ☐

***NOTE:** If maintaining coverage under another 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.*

You are covered under the other existing EHC as the:
☐ Member OR ☐ Spouse

Insurance Company _____ Policy Number _____

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

If you are not maintaining additional existing 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 the selected plan(s) will commence on the day after you or your spouse's plan terminates.
Termination Date of Your or Your Spouse's group benefits plan DD MM YYYY
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.*

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 DD MM YYYY	Dependents age 21+ ☐ Full Time Student age 24 or less ☐ Disabled
First Name(s)	Last Name		Gender ☐ Male ☐ Female
Provincial Health Registration #	Personal Health ID #	Date of Birth DD MM YYYY	Dependents age 21+ ☐ Full Time Student age 24 or less ☐ Disabled

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

3. MONTHLY PREMIUMS PAYMENT

☐ **Automatic Bank Withdrawal. I authorize** Johnson Inc., 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 April 5th deduction pays for May 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 Johnson Inc. receive two or more Non-Sufficient Funds (NSF) notices on my account.

☐ **Claim Payment Direct Deposit. I authorize** Johnson Inc. 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 Prestige Travel Insurance 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 this application is received. 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 Johnson Inc. in writing to the contrary, the coverage I have selected **will remain in effect for each policy year thereafter**. Johnson 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" Johnson Inc., and my "Insurers" Desjardins Financial Security and Royal & Sun Alliance Insurance Company of Canada (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, Dental Plan and/or Prestige 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 Johnson Inc. manages your personal information, please visit: https://www1.johnson.ca/protecting-your-privacy. For further information on how Royal & Sun Alliance Insurance Company of Canada manages your personal information, please visit: https://www.rsagroup.ca/your-privacy/privacy-policy.

_____ _____

Signature of Applicant **Date**

_____ _____

Signature of Spouse (if Couple or Family coverage selected) **Date**

PLEASE FORWARD YOUR APPLICATION TO:

JOHNSON INC.
GROUP BENEFITS
P.O. Box 4005, STN A
Toronto, ON M5W 0M7
Email: pbservicewest@johnson.ca

Please direct all inquiries about the application, policies, authorization for premium deductions or any written notice of change or cancellation to the Plan Administrator, Johnson Inc. at 1-877-989-2600 (Option #2) or pbservicewest@johnson.ca.