PACIFIC BLUE CROSS®

First Nations Health Authority
Health through wellness

DO NOT WRITE IN THIS SPACE

ENROLLMENT APPLICATION FOR GROUP BENEFITS

CLIENT — Please complete Parts 2 and 4 of this application and only complete Part 3, if applicable.
PLAN ADMINISTRATORS — Please complete Part 1 of this application.
Please complete form electronically or print clearly in **INK**. Sign, date and submit your application to your Plan Administrator as soon as possible.

☐ New Client ☐ Reinstatement

PART 1 — PLAN ADMINISTRATOR

Policy number	Name of company/organization		Status number
40000	First Nations Health Authority		
Effective date (mm-dd-yyyy)	**Class**	**Employment type**	**Hours per week**
		Client	0

If we have questions, how can we contact you? Telephone: 1 855 550-5454, press "2," then "1" Email: hb.eligibility@fnha.ca

PART 2 — CLIENT/DEPENDENT INFORMATION

Legal first name	Preferred name	Middle initial	Last name	Birthdate (mm-dd-yyyy)	Sex
					☐ M ☐ F

Street address	City	Province	Postal code

Email address

For children who have not yet received their own status number, please provide the information requested in the table below.

	LEGAL FIRST NAME	PREFERRED NAME	MIDDLE INITIAL	LAST NAME	BIRTHDATE (MM-DD-YYYY)	SEX
First child						☐ M ☐ F
Second child						☐ M ☐ F

PART 3 — CO-ORDINATION OF BENEFITS

If you or any of your dependents have coverage under another plan, please indicate the following:

Name of Insurance company	Group Policy Number	ID or certificate number

PART 4 — CLIENT SIGNATURE

I agree to the conditions of my benefit plan between First Nations Health Authority (FNHA) and Pacific Blue Cross. I confirm that the information I have provided is true and complete.

If I should receive a settlement or a judgement against a liable third party for wage loss or benefits covered under my group plan, I agree to and authorize the third party to reimburse Pacific Blue Cross up to the amount advanced to me pending such settlement or judgement.

I consent to Pacific Blue Cross collecting, using and disclosing my personal information where reasonably necessary for the purposes of my enrollment or coverage under this group plan. I consent to the disclosure of my personal information to agents and representatives of Pacific Blue Cross and other providers/insurers and their agents and representatives for the purposes of assessing and providing benefits coverage. I also consent to the disclosure of my personal information to my plan administrator when required or permitted by law or by contract between Pacific Blue Cross and FNHA; and to the retention, use and disclosure of my personal information in accordance with the Pacific Blue Cross privacy policy.

The privacy policy is available online at pac.bluecross.ca or by calling Pacific Blue Cross at 604 419-2000.

Client's signature	Date (mm-dd-yyyy)
X	

FNHA CLIENTS:

MAIL YOUR APPLICATION
First Nations Health Authority,
Health Benefits Department
501 – 100 Park Royal South
West Vancouver, BC V6B 4E1

FAX
1 888 299-9222

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