

**Instructions:** Please print all information in ink. Coverage is mandatory until employee provides proof of alternate coverage.

**Return to:** Nova Scotia Public Service Commission, Benefits, P.O. Box 943, Halifax, NS B3J 2V9.

**Section 1: Employee Information**

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

**Section 2: Family Information**

ELIGIBLE SPOUSE				
Last Name	First Name		Initial	
If common-law, effective date of cohabitation (DD/MM/YY)	Date of Birth (DD/MM/YY)	Gender (M/F)	A- Add C- Change D- Delete	

ELIGIBLE DEPENDENT CHILDREN								
Last Name	First Name	Initial	Gender (M/F)	Date of Birth			Dependent Status (*) if applicable	A- Add C- Change D- Delete
				DD	MM	YY		

(\*) **Dependent Status:**

'E' – Education, if dependent child is over age 21 and attending an accredited school, college or university an Overage Dependent Form is required  
 'S' – Special, if the dependent child is physically or mentally disabled (Medavie Blue Cross approval required)

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

Name of the Other Insurer	Effective Date of Coverage
Identification Number/Certificate Number	Policy Number
Name of Cardholder	Date of Birth (DD/MM/YY)

Please indicate **S** for Single or **F** for Family for the applicable benefits.

All:	Hospital:	Extended Health Benefits:	Vision:	Drugs:	Dental:
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**Section 4: Declaration and Authorization**

I certify that all information contained herein is correct and hereby authorize payroll deductions, if required. I authorize Blue Cross to collect, use and disclose my personal information. 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.

Date (DD/MM/YY)	Signature of Employee
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