

1. This section to be completed by employee				
Last name	First name	Middle initial	Birth date (YYYY-MM-DD)	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Mailing address		City	Province	Postal code
Primary phone	Secondary phone	Email		Participant coverage <input type="checkbox"/> Single <input type="checkbox"/> Family

2. Direct deposit information			
Bank account holder's name			
Bank account numbers (the image at right shows you where to find these numbers at the bottom of your cheque)	Cheque number    0 9 9	Transit : 0 9 9 9 9	Institution 0 9 9 1 : Account 0 9    0 9 9 9 9 9 9 9 9
Claim payments will be directly deposited into this bank account	Transit	Institution	Account

3. Please complete this section for spouse, common-law spouse or dependent information							
Last name	First name	Middle initial	Relationship <input type="checkbox"/> Married spouse <input type="checkbox"/> Common-law	Date of marriage or cohabitation (YYYY-MM-DD)	Birth date (YYYY-MM-DD)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Unmarried dependent children (if additional space is required, please complete the remainder of this section on a new page and submit it with this form)							
Last name	First name	Middle initial	Relationship	Birth date (YYYY-MM-DD)	Gender	If over the age of 21	
						Full-time student <input type="checkbox"/> Yes <input type="checkbox"/> No	Disabled dependent <input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

4. Please complete this section if you are waiving benefits			
I am waiving the following benefits as I am currently covered through my spouse's plan. <input type="checkbox"/> Health <input type="checkbox"/> Dental			
Group/policy number	Name of insurance company	I understand that if benefits have been waived, I will not be able to re-enrol for these benefits at a later date unless application occurs within 31 days of termination of spousal coverage.	I wish to waive the following, subject to the group contract participation requirements. <input type="checkbox"/> All Employee Life Insurance benefits and disability benefits

5. Coordination of benefits			
Do you have coverage through another insurance company? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please indicate below)			
Name of insured	Name of insurance company	Group/policy number	Benefits covered <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Drugs

6. Optional coverages	
Note: for Dependent Life Insurance, Optional Employee Life Insurance and Optional Employee Accidental Death and Dismemberment Insurance, the employee is the beneficiary of the insured spouse and children.	
<input type="checkbox"/> Optional Employee Life Insurance (must be in units of \$10,000) <input type="checkbox"/> Employee amount \$ _____ and/or <input type="checkbox"/> Spouse amount \$ _____	<input type="checkbox"/> Optional Employee Accidental Death and Dismemberment Insurance    Amount \$ _____ <input type="checkbox"/> Employee    or <input type="checkbox"/> Employee and eligible dependents

**7. This section to be completed by employer**

Name of group		Group number	Section	Effective date of coverage (YYYY-MM-DD)		
Employee number	Department ID	Other identity number	Hours worked per week	Date of hire (YYYY-MM-DD)		
				<input type="checkbox"/> Full time	<input type="checkbox"/> Part time	
Complete for Employee Life Insurance and disability benefits						
Employee class	Occupation			Salary \$ _____ Select the applicable <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually		
Complete for spending account benefits						
Spending account <input type="checkbox"/> Health Spending Account <input type="checkbox"/> Wellness Spending Account		Credit deposit date (YYYY-MM-DD)	Credit deposit amount	Frequency <input type="checkbox"/> Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly	Payment options <input type="checkbox"/> Automatic <input type="checkbox"/> Discretionary	

**8. Acknowledgment and consent**

I authorize Alberta Blue Cross, Blue Cross Life Insurance Company of Canada\* and/or its agents or affiliates to collect, use, maintain and disclose personal information for the purposes of determining eligibility for coverage, assessment, paying claims, audit, investigation, underwriting, administration and claim management. I acknowledge and agree that my personal information may only be collected from and/or released to a third party (health care professional/practitioner/insurer or reinsurer/agent of record/my employer) only when needed for a purpose stated above. I confirm that I am authorized by my spouse and dependents to receive and disclose information about them that is used solely for these purposes.

I understand that I can revoke this consent at any time in writing; however, if consent is withheld or revoked, coverage may be denied or rescinded. I understand why I have been asked to disclose this information and am aware of the risks and benefits of consenting, or refusing to consent, to the disclosure. I agree that this consent shall be effective on the date of this application and shall be valid for the duration of the time coverage is in effect. I agree that a copy or electronic version of this authorization shall be as valid as the original.

For a copy of our privacy policies, or questions about our personal information policies and practices, please refer to [ab.bluecross.ca](http://ab.bluecross.ca) or email our privacy compliance officer at [privacy@ab.bluecross.ca](mailto:privacy@ab.bluecross.ca).

By choosing to have direct deposit, I hereby authorize Alberta Blue Cross to deposit claims payments as indicated. By providing my email, I understand that I will no longer receive paper statements and instead I will receive an email notice when my statement has been posted to the member site. I understand that the direct deposit information and email address provided above will apply to all Alberta Blue Cross plans of which I am a member.

I certify that all the information on this form is true and complete and I acknowledge that all other Alberta Blue Cross coverage that I may have in place will remain active.

Employee signature	Date (YYYY-MM-DD)
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**Please do not email this form back to us, as email is not considered a secure form of transmission.**

**FORM SUBMISSION**

**EMPLOYEE:**

**Please submit this to your plan administrator. Please do not email this form, as email is not considered a secure form of transmission.**

**PLAN ADMINISTRATOR:**

**Please input this information into the plan administrator website. If you do not have access, please contact us to obtain online access.**

