ALBERTA BLUE CROSS®

HEALTH AND DENTAL LIFE AND DISABILITY CHANGES APPLICATION

10009 108 Street NW, Edmonton, Alberta T5J 3C5
Telephone: 780-498-8100 or 1-800-232-1914
Fax: 780-498-3540 **ab.bluecross.ca**

1. This section to be completed by employer

Name of group	Group number/section	ID number	Effective date of change (YYYY-MM-DD)

Last name	First name	Birth date (YYYY-MM-DD)

Type of change (check below and complete applicable sections)

☐ Transfer	Revised section	Revised employee class	
☐ Salary	COMPLETE FOR CHANGES IN EMPLOYEE LIFE INSURANCE AND DISABILITY BENEFITS Revised salary $_____ Per: ☐ Hourly *Hours worked per week* _____ ☐ Weekly ☐ Monthly ☐ Annually		
☐ Occupation	Revised occupation	Revised department ID	Revised other identity number

☐ Reinstatement—returned to work (YYYY-MM-DD) _____ ☐ Other (specify) _____

2. Change employee address, phone number or email

Mailing address	City	Province	Postal code

Primary phone	Secondary phone	Email

3. Change employee name or participant coverage

Last name	First name	Middle initial	Participant coverage
			☐ Single ☐ Family

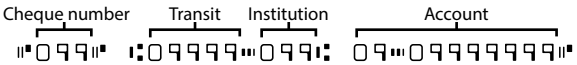
4. Please complete this section for family participant coverage

Add	Change	Delete	Last name	First name	Middle initial	Relationship	Date of marriage/ cohabitation (YYYY-MM-DD)	Birth date (YYYY-MM-DD)	Gender
☐	☐	☐				☐ Spouse ☐ Common-law			☐ M ☐ 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)

								If over the age of 21	
Add	Change	Delete	Last name	First name	Middle initial	Relationship	Birth date (YYYY-MM-DD)	Gender	Full-time student	Disabled dependent
☐	☐	☐						☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No
☐	☐	☐						☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No
☐	☐	☐						☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No

5. 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 Transit Institution Account 		
Claim payments will be directly deposited into this bank account	Transit	Institution	Account

6. Change in coverages (please check appropriate statement and indicate change in benefits)

☐ ADD the following benefits as coverage has been terminated under my spouse's plan. ☐ Health ☐ Dental ☐ Employee Life Insurance Benefit

Termination date of spouse's coverage (YYYY-MM-DD): _____

☐ WAIVE the following benefits as coverage has been added under my spouse's plan. ☐ Health ☐ Dental ☐ Vision ☐ Drugs

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.

☐ COORDINATE the following benefits with my spouse's plan. ☐ Health ☐ Dental ☐ Vision ☐ Drugs

Group/policy number _____ Name of insurance company _____

☐ WAIVE all Employee Life Insurance benefits and disability benefits.

Group/policy number _____ Name of insurance company _____

Waiving of these benefits is subject to your group's participation requirements.

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7. Change in 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.

Add	Change	Delete	Employee Optional Life Benefit (must be in units of $10,000)
☐	☐	☐	Employee amount $_____
☐	☐	☐	Spouse amount $_____

Add	Change	Delete	Optional Accidental Death and Dismemberment
☐	☐	☐	☐ Employee ☐ Employee and eligible dependants
			Amount $_____

8. Termination (check type of termination and indicate date)

- The employee must be provided with a copy of this form.
- Alberta residents may apply for Alberta Blue Cross® coverage on an individual basis through one of our personal benefit plans. To be eligible for continuous coverage, you must apply within 30 days of your group plan cancellation date.
- If you are retiring and are between the ages of 50 and 75 at the time of your application, you are eligible to apply for the retiree plan within 60 days of your group plan terminating. The retiree plan is available to all applicants with a Canadian provincial or territorial health insurance plan. Please contact Alberta Blue Cross at 1-800-661-6995 for details.

☐ Left employment	☐ Lay off	☐ Leave of absence	☐ Other (specify) _____	Date employment terminated (YYYY-MM-DD)
☐ Retired	☐ Maternity leave	☐ Deceased		

9. 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** or email our privacy compliance officer at **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)

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.