

1. THIS SECTION TO BE COMPLETED BY EMPLOYER

NAME OF GROUP		GROUP AND SECTION NUMBER		EFFECTIVE DATE OF CHANGE:	YYYY	MM	DD
EMPLOYEE SURNAME	GIVEN NAME	MIDDLE INITIAL	ID NUMBER	DATE OF BIRTH	YYYY	MM	DD
TYPE OF CHANGE (Check below and complete applicable sections.) <input type="checkbox"/> Transfer <input type="checkbox"/> Salary <input type="checkbox"/> Occupation <input type="checkbox"/> Reinstatement - Returned to work: <input type="checkbox"/> Other (Specify): _____							
REVISED DEPARTMENT / SECTION	REVISED EMPLOYEE NUMBER	REVISED OTHER IDENTITY NUMBER	REVISED OCCUPATION	REVISED EMPLOYEE CLASS:			
COMPLETE FOR CHANGES IN LIFE & DISABILITY BENEFITS		REVISED EARNINGS: \$	Per: <input type="checkbox"/> HOURS Hours worked/week	<input type="checkbox"/> WEEK	<input type="checkbox"/> MONTH	<input type="checkbox"/> YEAR	

2. CHANGE: EMPLOYEE ADDRESS and / or TELEPHONE NUMBER

NEW MAILING ADDRESS		CITY / TOWN	PROVINCE	POSTAL CODE
TELEPHONE: Home ()		Work ()		

3. CHANGE: EMPLOYEE NAME / BENEFIT STATUS

NEW SURNAME	GIVEN NAME	MIDDLE INITIAL	REVISED BENEFIT STATUS:
			<input type="checkbox"/> Single <input type="checkbox"/> Family

4. CHANGE: SPOUSE, COMMON-LAW SPOUSE and / or DEPENDENT(S) INFORMATION

Add	Change	Delete	SURNAME (If different than employee's)	GIVEN NAME AND MIDDLE INITIAL	GENDER	DATE OF BIRTH	PROVINCIAL HEALTH NUMBER	DATE OF MARRIAGE / COHABITATION	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spouse		<input type="checkbox"/> M <input type="checkbox"/> F	YYYY MM DD		YYYY MM DD	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Common law		<input type="checkbox"/> M <input type="checkbox"/> F				
UNMARRIED DEPENDENT CHILDREN: (NOTE: If additional space is required please use the back of this page.)									
Add	Change	Delete	SURNAME (If different than employee's)	GIVEN NAME AND MIDDLE INITIALS	RELATIONSHIP	GENDER	DATE OF BIRTH	PROVINCIAL HEALTH NUMBER	*CODE (See below)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> M <input type="checkbox"/> F	YYYY MM DD		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> M <input type="checkbox"/> F			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> M <input type="checkbox"/> F			
*CODES: A = An unmarried, fully dependent child less than the dependent age as specified in the booklet. B = An unmarried child over the dependent age but under the maximum age specified in the booklet. This dependent must be attending an accredited educational institution on a full-time basis. NOTE: Please enter the date school commences beside all code B dependents. An annual <i>Dependency Declaration</i> is required for each school year. C = An unmarried child, over the dependent age as specified in the Employee Benefits Booklet, but fully dependent on me due to mental or physical disability.									

5. CHANGE IN COVERAGES (Please check appropriate statement and indicate change in benefits.)

<input type="checkbox"/> ADD the following benefits as coverage has been terminated under my spouse's plan.	<input type="checkbox"/> Health <input type="checkbox"/> Dental
<input type="checkbox"/> DELETE the following benefits as coverage has been added to my spouse's plan.	Group number: _____ Name of insurance company: _____
<input type="checkbox"/> Health <input type="checkbox"/> Dental	I understand that if benefits have been deleted, 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.
<input type="checkbox"/> WAIVE ALL LIFE & DISABILITY BENEFITS	Waiving of these benefits is subject to your group's participation requirements. Group number: _____ Name of insurance company: _____

6. CHANGE IN OPTIONAL COVERAGES

Add	Change	Delete	OPTIONAL LIFE	Add	Change	Delete	OPTIONAL AD&D (Accidental Death and Dismemberment)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Employee Total Amount: \$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Employee <input type="checkbox"/> Employee and Eligible Dependents
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spouse Total Amount: \$ _____	Total Amount: \$ _____			
Note: • For Dependent Life, Optional Life and Optional AD&D the employee is the beneficiary of the insured spouse and children. • For adding or changing of beneficiary information, please complete a Beneficiary Appointment / Change form.							

7. TERMINATION: (Check type of termination and indicate date.)

<ul style="list-style-type: none"> 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 Individual Benefit Plans. To be eligible for continuous coverage you must apply within 30 days of your group plan cancellation date. Please contact Alberta Blue Cross at 1-800-661-6995 for details. 	<input type="checkbox"/> Left Employment <input type="checkbox"/> Maternity Leave <input type="checkbox"/> Other (Specify): _____ <input type="checkbox"/> Retired <input type="checkbox"/> Leave of Absence _____ <input type="checkbox"/> Lay off <input type="checkbox"/> Deceased _____	DATE EMPLOYMENT TERMINATED YYYY MM DD
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8. ACKNOWLEDGEMENT AND CONSENT

I certify that all the above information is correct and meets the contractual requirements outlined in the group contract. Employer Signature: _____ Date: _____	I certify that all the above information is true and complete and agree to the Acknowledgement and Consent on the reverse side of this form. Employee Signature: _____ Date: _____
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ACKNOWLEDGEMENT AND CONSENT

I certify that the information contained on this form is true and complete. I understand that the personal information provided herein about me and eligible dependents, as well as other personal information currently held or collected in the future by Alberta Blue Cross and/or Blue Cross Life Insurance Company of Canada*, may be used or disclosed only to determine eligibility for benefits; verify, assess and pay claims; administer the terms of my benefit plan and policy and to manage the Company's business. I certify that I am authorized by my spouse and/or other adult dependents to disclose and receive information about them that is used solely for these purposes.

I hereby acknowledge and agree that my/my dependents' personal information may be exchanged between only Alberta Blue Cross and a licensed physician and/or other health care professional, institution or health benefits provider or insurer or government or regulatory authority and only as needed for a purpose stated above.

I understand that my and my dependents' personal information will be kept confidential and secure. I understand that I may revoke this consent at any time and acknowledge that should I do so, the coverage may be denied or rescinded. I understand why my/my dependents' personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its use as described above.

I have read and understood this Acknowledgement and Consent and authorize Alberta Blue Cross to collect, use and disclose my/my dependents' personal information as described above. This consent shall be effective from the date of signature of this form and shall remain in effect as long as the coverage is in force.

For additional information regarding Alberta Blue Cross privacy policies, visit www.ab.bluecross.ca or contact Alberta Blue Cross at (780) 498-8100 ext. 8108.

*Blue Cross Life Insurance Company of Canada underwrites all life and income replacement benefits.