ALBERTA BLUE CROSS®

OVER-AGE DEPENDENT DECLARATION

Employee's last name		Employee's first name and initials		Date of birth (YYYY-MM-DD)
Email address			Group and section	ID number
Dependent's last name	First name and initials		Relationship	Date of birth (YYYY-MM-DD)

I declare that the above named dependent as defined in the Employee Benefits Booklet is (check appropriate box and enter dates as required)

☐ An unmarried child over the dependent age but under the maximum age specified in the Employee Benefits Booklet. This dependent must be attending an accredited educational institution on a full-time basis. (NOTE: An annual Over-age Dependent Declaration is required for each school year.)	Start of school term (YYYY-MM-DD)
Name of educational institution	End of school term (YYYY-MM-DD)

☐ An unmarried child, over the dependent age as specified in the Employee Benefits Booklet, but fully dependent on me due to a continuous mental or physical disability.

I certify that all the above information is true and complete and agree to the acknowledgement and consent below.
I understand and agree that it is my responsibility to advise Alberta Blue Cross immediately should the dependent named cease to be eligible.

Employee's signature	Date (YYYY-MM-DD)

ACKNOWLEDGEMENT AND CONSENT

I hereby authorize the release of medical and health information in my file by the healthcare provider listed on this form to Alberta Blue Cross, Blue Cross Life Insurance Company of Canada* and/or its authorized agents (collectively, the "Company") for the purposes of determining eligibility for coverage, assessment, paying claims, audit, investigation, underwriting, administration and claims management. This medical and health information includes, but is not limited to, copies of all consultation reports, my medical history, clinical notes, test results and hospital records. Medical and health information excludes genetic test results.

To the extent reasonably necessary for the above purposes, I authorize the Company to disclose any of the information received herein to a third party, which may include: a licensed physician and/ or other healthcare professional or institution, a health and life insurer, my employer and their insurance brokers, advisors or benefit plan administrators, a government or regulatory authority or any other person or company (including licensed physicians, healthcare professionals, rehabilitation workers and vocational evaluators) employed or engaged by the Company.

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 this information is needed and am aware of the risks and benefits of consenting, or refusing to consent, to the collection, use and/ or disclosure of this information.

I agree that this consent shall be effective on the date noted below and shall be valid for the duration of the time my benefit coverage is in force.

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 if you have questions about our personal information policies and practices, please refer to **ab.bluecross.ca** or email our privacy officer at **privacy@ab.bluecross.ca**.

Send the completed form to Alberta Blue Cross.

For more information about Alberta Blue Cross privacy policies or the collection, use or disclosure of yours and your dependents' personal information, visit **ab.bluecross.ca**, call our privacy matters representative at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 108 Street NW, Edmonton, AB T5J 3C5.

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

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