ALBERTA BLUE CROSS®

EMPLOYEE BENEFITS 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**

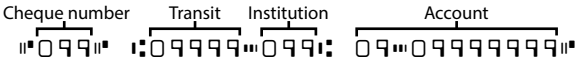
1. This section to be completed by employee

Last name	First name	Middle initial	Birth date (YYYY-MM-DD)	Gender ☐ M ☐ F

Mailing address	City	Province	Postal code

Home phone	Day time phone	Email	Participant coverage ☐ Single ☐ Family

2. Direct deposit information

Bank account holder's name (if different than above)			
Bank account numbers (The image 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

3. Please complete this section for spouse, common-law spouse, or dependent information

Last name	First name	Middle initial	Relationship	Date of common-law 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)

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

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. ☐ Health ☐ 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. ☐ All Employee Life Insurance benefits and Disability benefits

5. Coordination of benefits

Do you have coverage through another insurance company? ☐ No ☐ Yes (if yes, please indicate below)

Name of insured	Name of insurance company	Group/policy number	Benefits covered ☐ Health ☐ Dental ☐ Vision ☐ Drugs

6. Optional coverages

Note for Dependent Life Insurance, Optional Employee Life Insurance and Optional Employee Accidental Death and Dismemberment Insurance

☐ Optional Employee Life Insurance (must be in units of $10,000) ☐ Employee amount $_____ and/or ☐ Spouse amount $_____	☐ Optional Employee Accidental Death and Dismemberment Insurance Amount $_____ ☐ Employee or ☐ Employee and eligible dependents

7. Beneficiary for Employee Life Insurance benefits (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	Percentage (total must = 100%)
1.				
2.				

For designated beneficiaries who are minors I wish to appoint: _____ as Trustee to receive any amount due for any beneficiary considered a minor under the Provincial jurisdiction of residence.

Contingent beneficiaries:
In the event **ALL** above mentioned Beneficiaries are deceased I wish to appoint:

Last name	First name	Middle initial	Relationship	Percentage (total must = 100%)
1.				
2.				

8. 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)	
				☐ Full time	☐ Part time
Complete for Employee Life Insurance and Disability benefits					
Employee class	Occupation			Salary $_____ Select the applicable ☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually	
Complete for spending account benefits					
Spending account ☐ Health Spending Account ☐ Wellness Spending Account	Credit deposit date (YYYY-MM-DD)	Credit deposit amount	Frequency ☐ Annually ☐ Quarterly ☐ Monthly	Payment options ☐ Automatic ☐ Discretionary	

9. Acknowledgement 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. Please do not email this form back to us, as email is not considered a secure form of transmission.

Employee Signature: _____ Date: _____

For more information about Alberta Blue Cross privacy policies or the collection, use or disclosure of your/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 St NW, Edmonton, AB T5J 3C5. *Blue Cross Life Insurance Company of Canada underwrites all Employee Life and Disability Benefits.