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 **www.ab.bluecross.ca**

1. This section to be completed by employee

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

Mailing address	Province	City/town	Postal code

Home telephone	Work telephone	Email address	Benefit status
			☐ Single ☐ Family

2. Direct deposit information

Bank account holder's name

Bank account numbers

The image shows you where to find these numbers at the bottom of your cheque.

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

3. Please complete this section for family coverage

Relationship	Last name *(if different than employee's)*	First name	Middle initial	Gender	Birth date	Date of common law
☐ Spouse ☐ Common law				☐ M ☐ F	YYYY - MM - DD	YYYY - MM - DD

Unmarried dependent children (if additional space is required, please use the back of this page)

Relationship	Last name *(if different than employee's)*	First name	Middle initial	Gender	Date of birth	*Code *(see below)*
				☐ M ☐ F	YYYY - MM - DD	
				☐ M ☐ F	YYYY - MM - DD	
				☐ M ☐ F	YYYY - MM - DD	

***CODES:**
A = An unmarried, fully dependent child less than the dependant age as specified in the benefits booklet.
B = An unmarried child over the dependant age but under the maximum age specified in the booklet. This dependant must be attending an accredited educational institution on a full-time basis.
NOTE: Please enter the date school commences beside all code B dependants. An annual *Dependency Declaration* is required for each school year.
C = An unmarried child, over the dependant age as specified in the benefits booklet, but fully dependent on me due to mental or physical disability.

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 number	Name of insurance company	*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.*	I wish to waive the following, subject to the group contract participation requirements. ☐ All Life and Disability benefits

5. Coordination of benefits

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

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

6. Optional coverages applied for (for Dependent Life, Optional Life and Optional AD&D the employee is the beneficiary of the insured spouse and children)

☐ Optional Life (must be in units of $10,000) ☐ Employee amount $_____ ☐ Spouse amount $_____	☐ Optional AD&D Amount $_____	☐ Employee ☐ Employee and eligible dependants	Note: For Dependent Life, Optional Life and Optional AD&D the employee is the beneficiary of the insured spouse and children.

7. Beneficiary for life benefits (If additional space is required, please use the back of this page)

Last name	First name	Middle initial	Relationship	Percentage *(total must = 100%)*
1.				
2.				
3.				

8. Acknowledgement and consent

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.
I acknowledge that all other Alberta Blue Cross coverage that I may have in place will remain active.

Employee signature	Date
	YYYY - MM - DD

If direct deposit information is provided, please do not email the form back to us as email is not considered secure.

<table>
<tr><td colspan="8">This section to be completed by employer</td></tr>
<tr><td colspan="3">Name of group</td><td>Group</td><td>Section</td><td colspan="2">Effective date of coverage</td><td>YYYY - MM - DD</td></tr>
<tr><td>Department</td><td>Employee number</td><td>Other identity number</td><td>Occupation</td><td>Hours worked per week</td><td rowspan="2">Date of hire</td><td>☐ Full time</td><td>YYYY - MM - DD</td></tr>
<tr><td colspan="2">COMPLETE FOR CHANGES IN LIFE & DISABILITY BENEFITS</td><td>Employee class</td><td colspan="2">Earnings $_____
per ☐ hour ☐ week ☐ month ☐ year</td><td>☐ Part time</td><td>YYYY - MM - DD</td></tr>
<tr><td colspan="2">Spending account
☐ HSA ☐ WSA</td><td>Credit deposit date</td><td>Credit deposit amount</td><td colspan="2">Frequency
☐ Annually ☐ Quarterly ☐ Monthly</td><td colspan="2">Payment options
☐ Automatic ☐ Discretionary</td></tr>
<tr><td colspan="2">Completed for employer by
I hereby certify this employee meets the contractual requirements outlined in the group contract</td><td colspan="3">Name</td><td>Date
YYYY - MM - DD</td><td colspan="2">Telephone number</td></tr>
</table>

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

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 dependants, 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 dependants to disclose and receive information about them that is used solely for these purposes.

I hereby acknowledge and agree that my and my dependants' 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 dependants' 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 and my dependants' 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 and my dependants' 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.

By choosing to have direct deposit, I hereby authorize Alberta Blue Cross to deposit claims 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.

For more information about Alberta Blue Cross privacy policies or the collection, use or disclosure of yours and your dependants' personal information, visit www.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.