ALBERTA BLUE CROSS®

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

EMPLOYEE BENEFITS APPLICATION

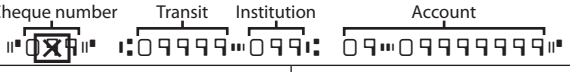
1. This section to be completed by employee

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

Mailing address	Province	City or town	Postal code

Home phone	Work phone	Email	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.)*	Cheque number Transit Institution Account 		
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 (YYYY-MM-DD)	Date of common law (YYYY-MM-DD)
☐ Spouse ☐ Common law				☐ M ☐ F		

Unmarried dependant 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	Birth date (YYYY-MM-DD)	*Code *(see below)*
				☐ M ☐ F		
				☐ M ☐ F		
				☐ M ☐ F		

***CODES:** A = An unmarried, fully dependant 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 below)***

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

6. Optional coverages applied for *(Note: for Dependant 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	

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.				

8. Acknowledgement and consent

I certify that all the above information is true and complete and agree to the acknowledgement and consent on page two. I acknowledge that all other Alberta Blue Cross coverage that I may have in place will remain active. If direct deposit information is provided, please do not email the form back to us as email is not considered secure.

Employee signature	Date (YYYY-MM-DD)

This section to be completed by employer

Name of group	Group	Section	Effective date of coverage (YYYY-MM-DD)

Department	Employee number	Other identity number	Occupation	Hours worked per week	Date of hire: ☐ Full time (YYYY-MM-DD)
					☐ Part time (YYYY-MM-DD)

COMPLETE FOR CHANGES IN LIFE & DISABILITY BENEFITS	Employee class	Earnings $_____ per ☐ hour ☐ week ☐ month ☐ year

Spending account ☐ HSA ☐ WSA	Credit deposit date	Credit deposit amount	Frequency ☐ Annually ☐ Quarterly ☐ Monthly	Payment options ☐ Automatic ☐ Discretionary

Completed for employer by ***(I hereby certify this employee meets the contractual requirements outlined in the group contract)***	Signature	Date (YYYY-MM-DD)	Phone

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

ACKNOWLEDGEMENT AND CONSENT

I authorize Alberta Blue Cross, Blue Cross Life Insurance Company of Canada* and/or its agents 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 dependants 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 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.