ALBERTA BLUE CROSS®

EMPLOYEE BENEFIT CHANGES

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 employer

Name of group			Group and section number	Effective date of change YYYY - MM - DD
Last name	First name	Middle initial	ID number	Birth date YYYY - MM - DD

Type of change (check below and complete applicable sections)

☐ Transfer ☐ Salary ☐ Occupation ☐ Reinstatement—returned to work YYYY - MM - DD ☐ 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 earning $	Per ☐ Hours	☐ Hours worked	☐ Week ☐ Month ☐ Year

2. ☐ Change employee address, telephone number and/or email

New mailing address	City/town	Province	Postal code
Telephone Home	Work	Email address	

3. ☐ Change employee name/benefit status

New last name	First name	Middle initial	Revised benefit status
			☐ Single ☐ Family

4. ☐ 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

5. ☐ Change spouse, common-law spouse and/or dependant information

Add	Change	Delete	Last name (If different than employee's)	First name and middle initial	Gender	Birth date	Date of marriage/ cohabitation
☐	☐	☐	Spouse		☐ M ☐ F	YYYY - MM - DD	YYYY - MM - DD
☐	☐	☐	Common law		☐ M ☐ F	YYYY - MM - DD	

Unmarried dependant children (NOTE: If additional space is required please use the back of this page.)

Add	Change	Delete	Last name (If different than employee's)	First name and middle initial	Relationship	Gender	Birth date	*Code (See below)
☐	☐	☐				☐ M ☐ F	YYYY - MM - DD	
☐	☐	☐				☐ M ☐ F	YYYY - MM - DD	
☐	☐	☐				☐ M ☐ F	YYYY - MM - DD	

***Codes:**

A = An unmarried, fully dependant child less than the dependant age as specified in the 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 Employee Benefits Booklet, but fully dependent on me due to mental or physical disability.

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

ABC 55069/20058 2017/09

6. Change in coverages (please check appropriate statement and indicate change in benefits.)

☐ **ADD** the following benefits as **coverage has been terminated** under my spouse's plan. ☐ **Health** ☐ **Dental** ☐ **Life**

☐ **DELETE** the following benefits as **coverage has been added** to my spouse's plan.

☐ **COORDINATE** the following benefits with my spouse's plan. ☐ **Health** ☐ **Dental**

Group/policy 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.

☐ **WAIVE** all Life and Disability benefits Group number _____ Name of insurance company _____

Waiving of these benefits is subject to your group's participation requirements.

7. Change in optional coverages

Add Change Delete **Optional life**

☐ ☐ ☐ Employee total amount $ _____

☐ ☐ ☐ Spouse total amount $ _____

Add Change Delete **Optional AD&D** (Accidental Death and Dismemberment)

☐ ☐ ☐ ☐ Employee ☐ Employee and eligible dependants total amount: $ _____

Note: For Dependent Life, Optional Life and Optional AD&D the employee is the beneficiary of the insured spouse and children.

8. Beneficiary for life benefits (if additional space is required, please use the bottom of this page)

Last name	First name	Middle initial	Relationship	Percentage *(total must = 100%)*
1.				
2.				
3.				
4.				

9. Termination (check type of termination and indicate date)

- 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.

☐ **Left employ** ☐ **Maternity leave** ☐ **Other (specify)** _____

☐ **Retired** ☐ **Leave of absence**

☐ **Lay off** ☐ **Deceased** _____

Date employment terminated

YYYY - MM - DD

10. Acknowledgement and consent

I certify that all of the information on the reverse side of this form 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 below.

Employee signature _____

Date _____

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

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/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 your/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 St NW, Edmonton, AB T5J 3C5. *Blue Cross Life Insurance Company of Canada underwrites all life and income replacement benefits.