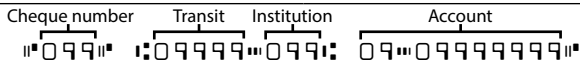


1. This section to be completed by employee				
Last name	First name	Middle initial	Birth date (YYYY-MM-DD)	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Mailing address		City	Province	Postal code
Home phone	Day time phone	Email		Participant coverage <input type="checkbox"/> Single <input type="checkbox"/> 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)			
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 Spouse <input type="checkbox"/> Common-law <input type="checkbox"/>	Date of common-law cohabitation (YYYY-MM-DD)	Birth date (YYYY-MM-DD)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Unmarried dependent children (if additional space is required, please use the back of this page)							
Last name	First name	Middle initial	Relationship	Birth date (YYYY-MM-DD)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Full time student <input type="checkbox"/> Yes <input type="checkbox"/> No	Disabled dependent <input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Health <input type="checkbox"/> 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.

5. Coordination of benefits			
Do you have coverage through another insurance company? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please indicate below)			
Name of insured	Name of insurance company	Group/policy number	Benefits covered <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Drugs

6. 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) <input type="checkbox"/> Full time <input type="checkbox"/> Part time
Complete for spending account benefits				
Spending account <input type="checkbox"/> Health Spending Account <input type="checkbox"/> Wellness Spending Account	Credit deposit date (YYYY-MM-DD)	Credit deposit amount	Frequency <input type="checkbox"/> Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly	Payment options <input type="checkbox"/> Automatic <input type="checkbox"/> Discretionary

## 7. 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](http://ab.bluecross.ca) or email our Privacy Compliance Officer at [privacy@ab.bluecross.ca](mailto: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: \_\_\_\_\_

