ALBERTA BLUE CROSS®

HEALTH AND DENTAL 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**

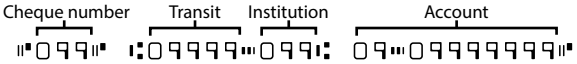
1. This section to be completed by employee

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

Mailing address	City	Province	Postal code

Daytime phone	Home phone	Email

2. Direct deposit information

Bank account holder's name			
Bank account numbers (the image to the right 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 marriage or cohabitation (YYYY-MM-DD)	Birth date (YYYY-MM-DD)	Gender
			☐ Married spouse ☐ Common-law			☐ M ☐ F

Unmarried dependent children: ☐ Check this box if you have more than 4 dependents. Please write out th eir information on the back of this form.

Last name	First name	Middle initial	Relationship	Birth date (YYYY-MM-DD)	Gender	If over the age of 21: Full-time student	If over the age of 21: Disabled dependent
					☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No
					☐ 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 employer plan. ☐ Health ☐ Dental ☐ Employee Family Assistance Program

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 my spouse's coverage.

5. Coordination of benefits

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

Benefits covered: ☐ Health ☐ Dental ☐ Vision ☐ Drugs

Name of insured	Birth date of insured (YYYY-MM-DD)	Group/policy number	Name of insurance company

ALBERTA BLUE CROSS®

HEALTH AND DENTAL BENEFITS APPLICATION

6. This section to be completed by employer

Group name		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 spending account benefits

Spending account	Credit deposit date (YYYY-MM-DD)	Credit deposit amount	Frequency	Payment options
☐ Health Spending Account *(non-taxable)* ☐ Wellness Spending Account *(taxable)*		$	☐ Monthly ☐ Quarterly ☐ Annually	☐ Automatic ☐ Discretionary

7. Acknowledgment 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.

Employee signature	Date (YYYY-MM-DD)

FORM SUBMISSION

EMPLOYEE:
Please submit this to your plan administrator.
Please do not email this form, as email is not considered a secure method of communication.

PLAN ADMINISTRATOR:
Please input this form's information or upload this form to the plan administrator website.
Please do not email this form, as email is not considered a secure method of communication.

*If you do not have access to the plan administrator site, email **groupeligibility@ab.bluecross.ca** or call **780-498-5925** or **1-866-498-5925 (toll free)** to request access.*

You can also mail or fax this form to Alberta Blue Cross using the contact information found at the top of this form.