ALBERTA BLUE CROSS®

HEALTH AND DENTAL CHANGES

10009 108 Street NW, Edmonton, Alberta T5J 3C5
Telephone: 780-498-5925 or 1-866-498-5925
Fax: 780-498-3540 **ab.bluecross.ca**

1. This section to be completed by employer

Name of group	Group number/section	ID number	Effective date of change (YYYY-MM-DD)

Last name	First name	Birth date (YYYY-MM-DD)

Type of change (check below and complete applicable sections)

☐ Transfer	Revised section	Revised department ID	Revised other identity number	Revised employee class

☐ **Reinstatement—returned to work** (YYYY-MM-DD):

☐ Other (specify)

2. Change employee address, phone number or email

Mailing address	City	Province	Postal code

Home phone	Day time phone	Email

3. Change employee name or participant coverage

Last name	First name	Middle initial	Participant coverage ☐ Single ☐ Family

4. Change spouse, common-law spouse or dependent information

Add Change Delete	Last name	First name	Middle initial	Relationship	Date of marriage/cohabitation (YYYY-MM-DD)	Birth date (YYYY-MM-DD)	Gender
☐ ☐ ☐				Spouse ☐ Common-law ☐			☐ M ☐ F

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

Add Change Delete	Last name	First name	Middle initial	Relationship	Birth date (YYYY-MM-DD)	Gender	Full time student	Disabled dependent
☐ ☐ ☐						☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No
☐ ☐ ☐						☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No
☐ ☐ ☐						☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No

5. Direct deposit information

Bank account holder's name (if different than employee name 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

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

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

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

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.

7. 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.
- If you are retiring and are between the ages of 50 and 75 at the time of your application, you are eligible to apply for the retiree plan within 60 days of your group plan terminating. The retiree plan is available to all applicants with a Canadian provincial or territorial health insurance plan. Please contact Alberta Blue Cross at 1-800-661-6995 for details.

☐ Left employ ☐ Lay off ☐ Leave of absence ☐ Other (specify) _____

☐ Retired ☐ Maternity leave ☐ Deceased

Date employment terminated (YYYY-MM-DD)

8. 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 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. Please do not email this form back to us, as email is not considered a secure form of transmission.

Employee signature: _____ Date: _____