ALBERTA BLUE CROSS®

OVER-AGE DEPENDANT DECLARATION

Employee's last name	Employee's first name and initials	Date of birth YYYY MM DD
Email address	Group and section	ID number
Dependant's last name / First name and initials	Relationship	Date of birth YYYY MM DD

I declare that the above named dependant as defined in the Employee Benefits Booklet is (check appropriate box and enter dates as required)

☐ An unmarried child over the dependant age but under the maximum age specified in the Employee Benefits Booklet.
This dependant must be attending an accredited educational institution on a full-time basis.
(NOTE: An annual Over-age Dependant Declaration is required for each school year.)

Name of educational institution

Start of school term YYYY MM DD

End of school term YYYY MM DD

☐ An unmarried child, over the dependant age as specified in the Employee Benefits Booklet, but fully dependent on me due to a continuous mental or physical disability.

I certify that all the above information is true and complete and agree to the acknowledgement and consent below.
I understand and agree that it is my responsibility to advise Alberta Blue Cross immediately should the dependant named cease to be eligible.

Employee's signature	Date YYYY MM DD	Employer's signature	Date YYYY MM DD

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 and 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.

Plan administrator: send the completed form to Alberta Blue Cross.

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.