

Submit this form directly to Alberta Blue Cross, Life & Disability Services (see contact information above).

Name of your employer	Your position or job title
-----------------------	----------------------------

Employee (plan member) information				
Last name		First name		Middle initial
Group/policy number	Section	ID number	Birth date (YYYY-MM-DD)	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Mailing address		City or town	Province	Postal code
Home phone	Work phone	Cellphone	Email	

Education
Formal education (list school, university, technical college, highest grade achieved including credits, diplomas and degrees)
Skills and training (please include on-the-job-training and duties, correspondence courses, apprenticeships, hobbies and interests, etc.)

Work history		
List all types of previous employment		
Name of employer	Date (YYYY-MM-DD)	Job title

Acknowledgement and consent
<p>I authorize Alberta Blue Cross, Blue Cross Life Insurance Company of Canada* and/or its agents 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) only when needed for a purpose stated above. Medical and health information excludes genetic test results. I confirm that I am authorized by my spouse and dependants to receive and disclose information about them that is used solely for these purposes.</p> <p>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I can revoke this consent at any time in writing; however, if consent is withheld or revoked, coverage may be denied or rescinded.</p> <p>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.</p> <p>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 force.</p> <p>I agree that a copy or electronic version of this authorization shall be as valid as the original.</p> <p>For a copy of our privacy policies, or questions about our personal information policies and practices, please visit our web site at ab.bluecross.ca or email our privacy compliance officer at privacy@ab.bluecross.ca.</p>

I hereby declare that the answers to the above questions are accurate and complete	
Signature of plan member	Date (YYYY-MM-DD)

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

** The Blue Cross symbol and name are registered marks of the Canadian Association of Blue Cross Plans, an association of independent Blue Cross plans. Licensed to ABC Benefits Corporation for use in operating the Alberta Blue Cross Plan. † Blue Shield is a registered trade-mark of the Blue Cross Blue Shield Association. ABC 55097/30297 2017/01

