ALBERTA BLUE CROSS®

# Individual Health Plans
# Request to remove a dependant

## Member information (please print)

| Member's last name | First name | Middle initial | Group number | Alberta Blue Cross ID number | |
|---|---|---|---|---|---|
| Address | City | | | Province | Postal code |
| Home phone number | Daytime phone number | Best time to call ☐ a.m. ☐ p.m. | Email address | | |

## Request to remove dependants

*List the dependants you wish to **remove** from your Alberta Blue Cross individual health plan*

| Last name (if different than member) | First name | Middle initial | Gender (M/F) | If deceased, please provide date of death (YYYY-MM-DD) |
|---|---|---|---|---|
| Member or co-applicant or spouse | | | | |
| Dependants | | | | |
| | | | | |
| | | | | |
| | | | | |

## Acknowledgment and consent (please read, date and sign below)

Failure to complete this request in its entirety will result in delays. Upon receipt of the completed request with all the required information and verification of all information, Alberta Blue Cross will provide a response within 30 days. If all the required information is not received within 60 days, Alberta Blue Cross will not act on this request.

**Acceptance**—upon accepting the request, Alberta Blue Cross will confirm termination by written confirmation with an effective date determined by Alberta Blue Cross.

**Use of your personal information**

I/we understand that the personal information provided herein 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 will only be collected, used, or disclosed to administer the terms of my/our Alberta Blue Cross individual health plan; verify my/our eligibility for coverage; verify, assess and pay claims; and develop and recommend suitable products and services to me/us. I/we acknowledge and agree that my/our or my dependants' personal information may only be collected from and/or released to a third party (health care professional/practitioner/institution or insurer/agent of record) only when needed for a purpose stated above. I/we certify that the member is authorized by his/her spouse and/or other adult dependants to disclose and receive information about them that is used solely for these purposes. I/we understand that my/our personal information will be kept confidential and secure.

**Your acknowledgment and consent**

I/we understand that I/we may revoke my/our consent at any time; however, if consent is withheld or revoked, the coverage may be denied or rescinded. I/we understand why my/our personal information is needed and are aware of the risks and benefits of consenting or refusing to consent to its disclosure. I/we have read and understood this complete request, including this acknowledgment and consent, and agree to all terms and conditions of the Agreement. I/we agree that this consent shall be effective from the date of the request and shall remain in effect as long as the agreement is in force, unless I revoke it in writing. I/we authorize the collection, use and disclosure of my/our personal information as described above.

Coverage will be terminated on a date determined by Alberta Blue Cross. I/we hereby understand and acknowledge that the requested dependants and/or spouse listed above in section B will no longer be eligible for the health and dental coverage underwritten by Alberta Blue Cross. Head Office: 10009 108 Stretty NW, Edmonton, Alberta T5J 3C5 and for the Accidental Death Insurance underwritten by Blue Cross Life Insurance Company of Canada. Corporate Office: 644 Main Street, P.O. Box 220, Moncton, New Brunswick E1C 8L3.

A photographic copy of this authorization shall be as valid as the original. This consent complies with provincial and federal privacy legislation.

**I/we have read and understood this form and certify that has been fully completed. I/we agree to the acknowledgment and consent on this form.**

**Date** (YYYY-MM-DD) _____

***This consent will be valid from this date, will continue while this agreement is in force and will end when agreement is cancelled.***

**Signature of member** _____

**Please print name here** _____

**Signature of co-Applicant/spouse** _____

**Please print name here** _____

| Please submit this completed form by only fax or mail | **FAX to**<br>**780-498-3531 or**<br>**1-877-498-3531 (toll free)** | **MAIL to**<br>**Alberta Blue Cross**<br>**10009 108 Street, NW Edmonton, AB T5J 3C5** |
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