ALBERTA BLUE CROSS®

EARLY NOTICE FORM

10009 108 Street NW, Edmonton, Alberta T5J 3C5
Telephone: 587-756-8631 or 1-800-763-6206
Fax: 780-441-2605 Toll-free fax: 1-855-660-2605
ab.bluecross.ca

Instructions:

1. Section 1 is to be completed by the employer.
2. Section 2 is to be completed by the employee (plan member).

Submit directly to Alberta Blue Cross, Life & Disability Services. See contact information above.

1. To be completed by the employer

Group/policy name	Group/policy number	Section

Employee (plan member) information

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

ID number	Mailing address	City/town	Province	Postal code

Home phone	Work phone	Email

Position information

Position/job title (as of last day worked) ☐ Part-time ☐ Full-time	Date last worked (YYYY – MM – DD)	Anticipated return to work (YYYY – MM – DD)

Comments

I hereby declare that the answers to the above questions are accurate and complete

Name (please print)	Signature	Date (YYYY – MM – DD)

Position/title	Phone	Fax	Email

2. Acknowledge and consent (to be completed by the employee)

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/my employer) only when needed for a purpose stated above. Medical and health information excludes genetic test results.
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I can revoke this consent at any time in writing; however, if consent is withheld or revoked, coverage may be denied or rescinded.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 force.
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 visit our website at ab.bluecross.ca or email our privacy compliance officer at privacy@ab.bluecross.ca.

Plan member name (please print)	Signature of plan member	Date (YYYY – MM – DD)

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

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