



SHADED AREA FOR BLUE CROSS USE ONLY

The completion and submission of this form will replace any prior beneficiary designations, unless you have previously designated irrevocable beneficiaries. If your last beneficiary designation was irrevocable, you will need to complete and attach a Waiver of Rights form found at ab.bluecross.ca.

1. MEMBER INFORMATION

Group name/personal plan		Group number	Section	ID number
Last name	First name		Middle initial	Birth date (YYYY-MM-DD)

All beneficiaries are considered revocable unless you live in the province of Quebec. If you wish to make your beneficiaries irrevocable, please complete and return the Irrevocable Designation form found at ab.bluecross.ca.

Residents of Quebec:

The beneficiary designation of your spouse will default to irrevocable. If you wish to designate your spouse as REVOCABLE, initial here: _____
 If a minor is designated as a beneficiary, the parent is automatically considered the tutor (trustee) of their child.

I revoke all previous appointments of beneficiaries and hereby appoint the following as beneficiaries entitled to receive the proceeds arising by reason of my death.

2. BENEFICIARY APPOINTMENT

Benefits will be paid to the beneficiaries as designated below. If you do not appoint a beneficiary, the benefits will be paid to your estate.

Check this box if you have more than 6 beneficiaries. Please write out their information on the back of this form.

Last name	First name	Middle initial	Birth date (YYYY-MM-DD)	Email and phone number	Relation to plan member	Percentage
				_____		%
				_____		%
				_____		%
				_____		%
				_____		%
				_____		%
<i>Total percentage must equal 100 per cent.</i>						%

3. TRUSTEE INFORMATION

If any designated beneficiary named above is a minor or lacks legal capacity, it is very important to name an **adult** who will receive the payment on behalf of the minor in accordance with their applicable provincial legislation. This is not applicable in the province of Quebec, where the parent is considered the tutor (trustee) of their child. **Attention: the trustee named below cannot be a minor.**

Last name	First name	Middle initial	Birth date (YYYY-MM-DD)	Email and phone number	Relation to plan member

4. CONTINGENT BENEFICIARY INFORMATION

In the event ALL of the above-named beneficiaries are deceased, benefits will be paid to your contingent beneficiaries.

Check this box if you have more than 4 contingent beneficiaries. Please write out their information on the back of this form.

Last name	First name	Middle initial	Birth date (YYYY-MM-DD)	Email and phone number	Relation to plan member	Percentage
				_____		%
				_____		%
				_____		%
				_____		%
<i>Total percentage must equal 100 per cent.</i>						%

5. APPLICABLE TERMS

Beneficiary: a revocable beneficiary can be changed or removed at any time by you alone.

Irrevocable beneficiary: an irrevocable beneficiary is designated by you but cannot be removed without the express permission from the beneficiary that you named. You will need to fill out a separate form and get their signature if you would like to remove or change their information in the future. If you name a minor as an irrevocable beneficiary, they cannot be removed until after they become a legal adult.

6. ACKNOWLEDGMENT AND CONSENT

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. I confirm that I am authorized by my beneficiaries 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 refusal to consent, to the disclosure. I agree that this consent shall be effective from the date of my signature on this form 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.

We are not able to accept digital signatures. Please sign below with a blue ink pen.

By providing my signature below, I agree to the acknowledgment and consent section and certify that all this information is true and complete.

Member signature	Date (YYYY-MM-DD)
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<p>FORM SUBMISSION</p> <p>Please upload this completed form to the Alberta Blue Cross member services website. Please do not email this form, as email is not considered a secure method of communication.</p>	<p>MAIL 10009 108 Street NW Edmonton, Alberta T5J 3C5</p> <p>FAX 780-498-3540</p>
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Please retain a copy for your records.

