

SHADED AREA FOR BLUE CROSS USE ONLY

BENEFICIARY

Appointment Change

Telephone: 780-498-8100 or 1-800-232-1914
 Fax: 780-498-3540 ab.bluecross.ca

| | | |
|----------------------------|---|----------------------------------|
| Group name/individual plan | Group number and section | Member's ID number |
| Member's last name | Member's first name and middle initials | Member's birth date (YYYY-MM-DD) |

In accordance with the terms and conditions of the Life Insurance Contract with Blue Cross Life Insurance Company of Canada, I revoke all previous appointments of beneficiary and hereby appoint the following as beneficiary entitled to receive the proceeds arising by reason of my death.

Beneficiaries

| Last name | First name | Middle initials | Relationship | Percentage |
|-----------|------------|-----------------|--------------|------------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

Total percentage must equal 100%.

For designated beneficiaries who are minors I wish to appoint: _____
 as Trustee to receive any amount due for any beneficiary considered a minor under the Provincial jurisdiction of residence.

Contingent beneficiaries:

In the event **ALL** above named beneficiaries are deceased I wish to appoint:

| Last name | First name | Middle initials | Relationship | Percentage |
|-----------|------------|-----------------|--------------|------------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

Total percentage must equal 100%.

I certify that all the above information is true and complete and agree to the Acknowledgement and Consent on the reverse side of this form.

| | |
|-------------------------|--------------------------|
| Member signature | Date (YYYY-MM-DD) |
|-------------------------|--------------------------|

| | |
|-----------------------------|--------------------------|
| FOR GROUP PLANS ONLY | |
| Employer's signature | Date (YYYY-MM-DD) |

Distribution: Please mail or fax a completed, signed copy to **Alberta Blue Cross**. Retain a copy for your records.



ACKNOWLEDGEMENT 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 spouse and dependants 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 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 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**

By choosing to have direct deposit, I hereby authorize Alberta Blue Cross to deposit claims as indicated. By providing my email, I understand that I will no longer receive paper statements and instead I will receive an email notice when my statement has been posted to the member site. I understand that the direct deposit information and email address provided above will apply to all Alberta Blue Cross plans of which I am a member.

For more information about Alberta Blue Cross privacy policies or the collection, use or disclosure of yours and your dependants' personal information, **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.