ALBERTA BLUE CROSS®

EMPLOYEE BENEFIT CHANGES

10009 108 Street NW, Edmonton, Alberta T5J 3C5
Telephone: 780-498-5925 and 1-866-498-5925
Fax: 780-498-3540 **ab.bluecross.ca**

1. This section to be completed by employer

Name of group	Group number/section	ID number	Effective date of change (YYYY-MM-DD)

Last name	First name	Birth date (YYYY-MM-DD)

Type of change (check below and complete applicable sections)

☐ Transfer	Revised section	Revised employee class	
☐ Salary	COMPLETE FOR CHANGES IN LIFE & DISABILITY BENEFITS Revised salary $_____ Per: ☐ Hourly Hours worked/week _____ ☐ Weekly ☐ Monthly ☐ Annually		
☐ Occupation	Revised occupation	Revised department ID	Revised other identity number
☐ **Reinstatement—returned to work** (YYYY-MM-DD)		☐ Other (specify)	

2. Change employee address, phone number or email

Mailing address	City	Province	Postal code

Home phone	Day time phone	Email

3. Change employee name or participant coverage

Last name	First name	Middle initial	Participant coverage ☐ Single ☐ Family

4. Please complete this section for family participant coverage

Add Change Delete	Last name	First name	Middle initial	Relationship	Date of marriage/cohabitation (YYYY-MM-DD)	Birth date (YYYY-MM-DD)	Gender
☐ ☐ ☐				Spouse ☐ Common law ☐			☐ M ☐ F

Unmarried dependent children (if additional space is required, please complete the remainder of this section on a new page and submit it with this form)

Add Change Delete	Last name	First name	Middle initial	Relationship	Birth date (YYYY-MM-DD)	Gender	Full time student	Disabled dependent
☐ ☐ ☐						☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No
☐ ☐ ☐						☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No
☐ ☐ ☐						☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No

5. Direct deposit information

Bank account holder's name			
Bank account numbers (The image shows you where to find these numbers at the bottom of your cheque)	Cheque number Transit Institution Account		
Claim payments will be directly deposited into this bank account	Transit	Institution	Account

6. Change in coverages (please check appropriate statement and indicate change in benefits)

☐ ADD the following benefits as coverage has been terminated under my spouse's plan. ☐ Health ☐ Dental ☐ Life

☐ WAIVE the following benefits as coverage has been added to my spouse's plan.

☐ COORDINATE the following benefits with my spouse's plan. ☐ Health ☐ Dental ☐ Vision ☐ Drugs

Group/policy number _____ Name of insurance company _____

I understand that if benefits have been waived, I will not be able to re-enrol for these benefits at a later date unless application occurs within 31 days of termination of spousal coverage.

☐ WAIVE all Life and Disability benefits Group/policy number _____ Name of insurance company _____

Waiving of these benefits is subject to your group's participation requirements.

7. Change in optional coverages

Note: for Dependent Life, Optional Life and Optional AD&D, the employee is the beneficiary of the insured spouse and children

Add Change Delete Optional Life (must be in units of $10,000)

☐ ☐ ☐ Employee amount $ _____

☐ ☐ ☐ Spouse amount $ _____

Add Change Delete Optional AD&D (Accidental Death and Dismemberment)

☐ ☐ ☐ ☐ Employee ☐ Employee and eligible dependants

Amount $ _____

8. Beneficiary for life benefits (If additional space is required, please complete the remainder of this section on a new page and submit it with this form.)

Last name	First name	Middle initial	Relationship	Percentage (total must = 100%)
1.				
2.				

9. Termination (check type of termination and indicate date)

- The employee must be provided with a copy of this form.
- Alberta residents may apply for Alberta Blue Cross coverage on an individual basis through one of our individual benefit plans. To be eligible for continuous coverage, you must apply within 30 days of your group plan cancellation date.
- If you are retiring and are between the ages of 50 and 75 at the time of your application, you are eligible to apply for the Retiree Plan within 60 days of your group plan terminating. The Retiree Plan is available to all applicants with a Canadian provincial or territorial health insurance plan. Please contact Alberta Blue Cross at 1-800-661-6995 for details.

☐ Left employ ☐ Lay off ☐ Leave of absence ☐ Other (specify)

☐ Retired ☐ Maternity leave ☐ Deceased _____

Date employment terminated (YYYY-MM-DD)

10. Acknowledgement and consent

I certify that all of the information on this form is true and complete and agree to the acknowledgement and consent below.
If direct deposit information is provided, please do not email the form back to us as email is not considered secure.

Employer signature _____

Date (YYYY-MM-DD) _____

Employee signature _____

Date (YYYY-MM-DD) _____

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 payments 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 your/your dependants' personal information, visit ab.bluecross.ca, call our privacy matters representative at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 108 St NW, Edmonton, AB T5J 3C5. *Blue Cross Life Insurance Company of Canada underwrites all life and income replacement benefits.