MEDAVIE BLUE CROSS™

CHANGE FORM

644 MAIN ST PO BOX 220 MONCTON NB E1C 8L3
230 BROWNLOW AVE DARTMOUTH PO BOX 2200 HALIFAX NS B3J 3C6
FOR ALL INQUIRIES: TEL 1-800-667-4511 FAX 506-869-9653

THIS AREA MUST BE COMPLETED FOR CHANGES TO BE PROCESSED

Existing Identification Number _____

Existing Policy and Section Number _____

Last Name _____

Instructions:
1) Earnings information is only required if life and/or income replacement benefits apply.
2) Employer to forward original and keep second copy.
3) The Optional Group Life Insurance Statement of Health form must be completed when an ADD or CHANGE is requested for Optional Life benefits. The **actual** amount of coverage must be stated (not the amount of the increase / decrease).

TYPE OF CHANGE - CHECK (✓)

☐ Address ☐ Marital Status ☐ Beneficiary ☐ Left Employ ☐ Cancel Benefits: Reason _____
☐ Dependent(s) ☐ Retired ☐ Telephone No. ☐ Salary ☐ Add Benefits: Reason _____
☐ Benefits ☐ Deceased ☐ Occupation ☐ Transfer ☐ Other: _____

COMPLETE ONLY AREAS AFFECTED BY THE CHANGE AND SIGN

Employee Last Name

Address (Street & No.)

City or Town

Province | Telephone No. ( )

Postal Code | Language Preferred ☐ English ☐ French

FIRST NAME INITIAL	Surname (if different from applicant)*	SEX M/F	BIRTH DATE DD	MM	YY	Dependent Status	A-Add C-Change D-Delete
Employee						E- Student (College/ University) S-Disabled	
Spouse							
Children							

* IF APPLICANT AND SPOUSE ARE NOT LEGALLY MARRIED, PLEASE PROVIDE COMMENCEMENT DATE OF CO-HABITATION _____

COORDINATION OF BENEFITS

Do you or any of your dependents have other coverage under any other Insurer? ☐ Yes ☐ No **If Yes, complete the following:**

Name of the Other Insurer: _____ Effective Date of Coverage: _____

Identification Number/Certificate Number: _____ Policy Number: _____

Is the Coordination of Benefits Single Coverage or Family Coverage? Please indicate under "Type of Coverage" S for Single or F for Family for the applicable benefits.

Type of Coverage: All _____ Hospital _____ Extended Health Benefits _____ Vision _____ Drugs _____ Dental _____

BASIC COVERAGE ❑ ADD ❑ CHANGE ❑ DELETE

☐ Life ☐ Long Term Disability ☐ Dependent Life
☐ Health ☐ AD & D ☐ Weekly Indemnity
☐ Dental ☐ Critical Conditions

Dependent life is automatically included if you indicate family status and eligible dependents.

STATUS CHANGE

☐ Single
☐ Family

OPTIONAL COVERAGES ☐ ADD ☐ CHANGE ☐ DELETE

Life (state total amt.) Employee $ _____ Spouse $ _____
AD&D (state total amt.) ☐ Single ☐ Family $ _____
Dependent Child Life ☐ YES ☐ NO

CHANGE OF BENEFICIARY - In accordance with the terms and conditions of the Group Life Contract between the employer indicated below and 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.

	Beneficiary Last Name	First Name	Initial	Relationship	Percentage
1.					
2.					
3.					

For designated beneficiaries under the age of 18: I appoint _____ as Trustee to receive any amount due for any beneficiary considered a minor under the Provincial jurisdiction of residence.

MARITAL CHANGE - When an employee requests a change from single to family coverage within 31 days of marriage, family coverage will become effective as outlined in the Medavie Blue Cross group benefits contract. If later than 31 days, a statement of health may be required.

Date of change in marital status:

DD _____ MM _____ YY _____

If spouse has Medavie Blue Cross benefits please complete:

Policy Number _____ Identification Number _____ Last Name _____

AUTHORIZATION OF CHANGE - I certify that the information above is accurate and authorize payroll deductions, if required. I authorize Blue Cross to collect, use and disclose my personal information as described in the Privacy Statement on the reverse of this form.

Employee Signature _____ Witness Signature _____ Date _____

TO BE COMPLETED BY EMPLOYER

Name of Employer	Policy and Section Number	Class of Coverage - Health and/or Dental	Employee Class - Life and/ or Disability Income	Occupation

Effective Date of Change DD	MM	YY	Complete for Life and Disability Income Benefits Earnings Per	Hours Worked Per Week	Payroll No. (maximum 9 positions)	Completed for Employer by
			☐ Hour ☐ Month ☐ Week ☐ Year $ _____		(1) _____ (2) _____	Signature _____ Date _____

BLUE CROSS LIFE INSURANCE COMPANY OF CANADA UNDERWRITES ALL LIFE AND DISABILITY INCOME BENEFITS.

PRIVACY STATEMENT

I understand that the personal information provided herein, as well as any other personal information currently held or collected in the future by Medavie Blue Cross and/or Blue Cross Life Insurance Company of Canada, may be collected, used, or disclosed to administer the terms of my policy or the group policy of which I am an eligible member, to recommend suitable products and services to me, and to manage Blue Cross's business. Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These third parties include other Blue Cross organizations, health care professionals or institutions, life and health insurers, government and regulatory authorities, and other third parties when required to administer and manage the benefits outlined in the policy of which I am an eligible member.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time, however, in some instances doing so may prevent Blue Cross from providing me with the requested coverage or benefits. I understand why my personal information is needed and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure.

A photocopy of this authorization shall be as valid as the original. This consent complies with federal and provincial privacy laws. For additional information regarding privacy policies at Medavie Blue Cross, visit www.medavie.bluecross.ca or call 1-800-667-4511.