MEDAVIE BLUE CROSS™

CHANGE FORM

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Instructions:

1) Earnings information is only required if life and/or income replacement benefits apply.
2) The Optional Group Life Insurance Statement of Health and Smoking Questionnaires must be completed when an ADD or CHANGE is requested for Optional Life or Optional Critical Illness benefits. The **actual** amount of coverage must be stated (not the amount of the increase / decrease).

THIS AREA MUST BE COMPLETED FOR CHANGES TO BE PROCESSED

Existing ID Number: _____ Payroll Number: _____

Existing Policy and Section Number: _____ Last Name: _____

1 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: _____

2 COMPLETE ONLY AREAS AFFECTED BY THE CHANGE AND SIGN

Employee First Name: _____ Employee Last Name: _____

Address (Street & Number): _____

City/Town: _____ Province: _____ Postal Code: _____

Date of Birth: _____ Telephone Number: _____ Language Preferred: ☐ English ☐ French

Spouse (if applicable) ☐ ADD ☐ CHANGE ☐ DELETE

First Name: _____ Middle Initial: _____ Last Name: _____

Gender: ☐ Male ☐ Female Birth Date (DD/MM/YYYY): _____

Status: ☐ Married ☐ Common-Law Date of co-habitation if common-law (DD/MM/YYYY): _____

Dependent Children (if applicable)

First Name	Last Name	Date of Birth (DD/MM/YYYY)	Gender M/F	Dependent Status	A - Add C - Change D - Delete
			☐ Male ☐ Female	☐ Disabled ☐ Student - College/University	☐ A ☐ C ☐ D
			☐ Male ☐ Female	☐ Disabled ☐ Student - College/University	☐ A ☐ C ☐ D
			☐ Male ☐ Female	☐ Disabled ☐ Student - College/University	☐ A ☐ C ☐ D

OTHER COVERAGE (CO-ORDINATION OF BENEFITS) ☐ ADD ☐ CHANGE ☐ DELETE

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

Name of the Other Insurer: _____ Effective Date of Coverage (DD/MM/YYYY): _____

Policy Number: _____ ID Number: _____ **Type of Coverage:** ☐ Hospital ☐ Vision ☐ EHB ☐ Drugs ☐ Dental ☐ All

Name of Employer: _____

Name of Person(s) insured under other policy	Date of Birth DD	MM	YYYY	Name of Person(s) insured under other policy	Date of Birth DD	MM	YYYY

BASIC COVERAGE ☐ ADD ☐ CHANGE ☐ DELETE

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

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

☐ HCSA Allocation $ _____ ☐ PSA Allocation $ _____

STATUS CHANGE ☐ Single ☐ Family

OPTIONAL COVERAGE ☐ ADD ☐ CHANGE ☐ DELETE

Optional Life: ☐ Employee Employee Amount $ _____ ☐ Spouse Spouse Amount $ _____

Optional Dependent Child Life: Amount $ _____

Optional Critical Illness: ☐ Employee Employee Amount $ _____ ☐ Spouse Spouse Amount $ _____

☐ Child Child Amount $ _____

Optional Accidental Death & Dismemberment: ☐ Employee Only ☐ Employee & Family Amount $ _____

If applying for Optional Coverage, the Non-Smoker Questionnaire and Statement of Health Forms may also be required.

2 COMPLETE ONLY AREAS AFFECTED BY THE CHANGE AND SIGN (cont.)

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. Surviving beneficiaries will share equally unless otherwise indicated.

First Name	Last Name	Percentage (Must total 100%)	Relationship	Revocable	Irrevocable
				☐	☐
				☐	☐
				☐	☐
				☐	☐

	First Name	Last Name	Date of Birth (DD/MM/YYYY)	Percentage (Must total 100%)	Relationship	Telephone Number
Contingent						
Contingent						

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

By choosing irrevocable, no future changes to your beneficiary designation will be permitted without the written consent of that beneficiary(ies) when the beneficiary(ies) is/are the age of majority.

IN QUEBEC, THE DESIGNATION OF YOUR SPOUSE AS BENEFICIARY IS PRESUMED IRREVOCABLE UNLESS OTHERWISE SPECIFIED.

For the province of Quebec - Where the beneficiary of a life insurance policy is a minor at the time of the insured's death, Medavie Blue Cross will pay the proceeds to parent(s) (or other legal guardian, if applicable), and not to anyone else who might be named as administrator/trustee of the proceeds. If you wish to have another person administering the child's proceeds, you should ensure you have the proper provisions in your will. You may also want to consult with a legal counsel to determine whether there are some estate planning steps you can take to support your wishes.

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 form may be required.

Date of change in Marital Status (DD/MM/YYYY): _____

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.

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 medaviebc.ca or call 1-800-667-4511.

Employee Signature: _____ Date: _____

Witness Signature: _____ Date: _____

3 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/YYYY): _____

Complete for Life and Disability Income Benefits: Earnings per ☐ Hour ☐ Month ☐ Week ☐ Year $ _____ Hours Worked Per Week: _____

Payroll Number (Maximum 9 positions): (1) _____ (2) _____

Completed for Employer by:

Signature: _____ Date: _____