



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, FIRST NAME, INITIAL, Surname (if different from applicant)\*, SEX M/F, BIRTH DATE DD MM YY, Dependent Status, A-Add C-Change D-Delete, \* IF APPLICANT AND SPOUSE ARE NOT LEGALLY MARRIED, PLEASE PROVIDE COMMENCEMENT DATE OF CO-HABITATION

OTHER COVERAGE

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:
Policy Number: ID Number:
Policy Owner:

Table with columns: Name of Person(s) insured under other policy, Date of Birth (Day, Month, Year)

Type of Coverage: Hospital, Vision, EHB, Drugs, Dental, All

BASIC COVERAGE (ADD, CHANGE, DELETE), STATUS CHANGE (Single, Family), OPTIONAL COVERAGES (Life, AD&D, Dependent Child Life)

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.

Table with columns: Last Name, First Name, Percentage, Relationship, Revocable, Irrevocable

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.

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 YY, 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, Complete for Life and Disability Income Benefits, Hours Worked Per Week, Payroll No., Completed for Employer by (Signature, Date)

## 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](http://www.medavie.bluecross.ca) or call 1-800-667-4511.