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 Division 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 ◯ TERMINATION

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

Sex*: ◯ Male ◯ Female ◯ Intersex ◯ Undisclosed Birth Date (DD/MM/YYYY): _____

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

* Sex: Male/Female/Intersex/Undisclosed – *Why do we ask?* Some health conditions are more likely to occur based on sex. As a result, sex is used to assess your coverage. We recognize that your sex may differ from your gender identity.

Dependent Children (if applicable)

First Name	Last Name	Date of Birth (DD/MM/YYYY)	Sex M/F/I/U	Dependent Status	A - Add C - Change D - Delete
			◯ M ◯ F ◯ I ◯ U	◯ Disabled ◯ Student - College/University	◯ A ◯ C ◯ D
			◯ M ◯ F ◯ I ◯ U	◯ Disabled ◯ Student - College/University	◯ A ◯ C ◯ D
			◯ M ◯ F ◯ I ◯ U	◯ 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 $ _____

Modular/Flex options *(Please indicate your chosen Module if you have a Modular/Flex plan)*: _____

STATUS CHANGE ◯ Single ◯ Family

3. OPTIONAL COVERAGE (PLEASE CONFIRM APPLICABLE BENEFITS WITH YOUR GROUP ADMINISTRATOR)

OPTIONAL COVERAGE ◯ ADD ◯ CHANGE ◯ DELETE

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

Do you use tobacco products? ◯ Yes ◯ No

Answer "No" if you have not used any nicotine or used any smoking cessation products in any form (including e-cigarettes) in the past 12 months.

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 $ _____

4. COMPLETE ONLY AREAS AFFECTED BY THE CHANGE AND SIGN

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 understand that the personal information I have provided herein is collected and used by Medavie Blue Cross to administer the terms of my policy or the group policy of which I am an eligible member, recommend suitable products and services that I am eligible for as a member of a policy, and other applicable purposes, as described in the Medavie Blue Cross Privacy Statement at medaviebc.ca.

Depending on the type of coverage I carry, limited personal information such as claim, health and/or financial related data may be collected from and/or released to following third parties as required for the purposes of administering and managing the benefits outlined in the policy of which I am an eligible member. These third parties may include healthcare providers, other insurance companies, regulatory authorities and investigative bodies, services providers, and/or the cardholder of any contract under which I am a participant.

Where allowed by law, my information may be shared with Medavie Blue Cross employees or service providers in jurisdictions other than where it was collected. If I am a resident of Quebec, this includes transferring or disclosing my personal information to Medavie Blue Cross employees or service providers outside of that province.

I understand that my consent is only valid for the time it is needed to achieve the purposes outlined herein, unless I withdraw it. I understand I may withdraw my consent at any time. However, in some instances doing so may prevent Medavie Blue Cross from providing me with certain products or services that may be useful to me and/or my dependents. This consent complies with federal and provincial privacy laws.

For more details about our information practices, including how your personal information is protected, how to access or correct personal information, or if you have concerns or questions, please see our Medavie Blue Cross Privacy Statement available at medaviebc.ca or call 1-800-667-4511.

Employee Signature: _____ Date: _____

Witness Signature: _____ Date: _____

5. TO BE COMPLETED BY EMPLOYER

Name of Employer: _____ Policy and Division 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: _____