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1981 MCGILL COLLEGE AVENUE, SUITE 100 MONTREAL, QC H3A 3A7 TEL: 1-888-588-1212 FAX: 1-514-286-8444 administration@medavie.bluecross.ca

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 ADEA MUST BE	E COMPLETED FOR CH	ANGES TO BE DOC	CESSE	n								
	er:					D	avroll Number					
	l Division Number:											
1. TYPE OF CHAN												
O Address	O Marital Status	O Beneficiary	0.1	_eft Emp	alov O	Cana	el Benefits: Reason					
O Dependent(s)	O Retired	O Telephone No		Salary	/		Benefits: Reason					
O Benefits	O Deceased	O Occupation		Fransfer		Othe						
2 COMPLETE OF	NLY AREAS AFFECTE	D BY THE CHAN	IGE AN	ID SIGN	J							
	me:					nnlove	e Last Name:					
						' '						
	Number):							D 1 10	1			
								Languag	ge Preferred: O Er	nglish	O Fre	nch
Spouse (if applical	•			RMINAT			1 (8)					
	Female O Intersex	O Undisclose	d	Birth Do	ate (DD/M/	M/YYY\	′):					
	ed O Common-Law						9					
	itersex/Undisclosed – <i>Wh</i> our sex may differ from yo		nealth co	onditions	are more	likely to	o occur based on sex. A	As a result, sex is u	used to assess your cove	rage.		
Dependent Childre	n (if applicable)											
Fi	rst Name		La	ıst Nam	e		Date of Birth	Sex	Dependent S	tatus	A - A	Add Change
							(DD/MM/YYYY)	M/F/I/U	<u>'</u>			Delete
								OM OF OI OU	O Disabled O Student - College/	'Universit	y OA	OC OD
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OTHER COVERAG	GE (CO-ORDINATION	OF BENEFITS)	О	ADD	о СН	ANGE	O DELETE					
Do you or any of yo	our dependents have o	coverage under a	ny othe	r Plan?	O Yes	ON	o If Yes, Comp	lete the follow	ing:			
Name of the Other	r Insurer:						Effective D	Oate of Coverag	ge (DD/MM/YYYY):			
Policy Number:	ID	Number:				Type o	f Coverage: O Hos	pital O Vision	O EHB O Drugs	O De	ental () All
Name of Employer	:											
. ,				Date of E	Birth	7 [Date of E	Birth
Name of Pe	erson(s) insured under of	ther policy	DD	MM	YYYY		Name of Perso	n(s) insured unde	er other policy	DD	MM	YYYY
						4						
					-	4 -						
BASIC COVERAG			DELE.									
	-	O Dependent Life		Health (AD & [,	lemnity O l	Dental O Critico	al Illness		
	utomatically included				-							
	n\$											
· · · · · · · · · · · · · · · · · · ·	ons (Please indicate you		ıf you h	ıave a №	1odular/F	lex plo	ın):					
STATUS CHANGE	O Single O	Family										
3. OPTIONAL CO	VERAGE (PLEASE C	ONFIRM APPLIC	ABLE	BENEFI	TS WITH	YOU	R GROUP ADMINIS	TRATOR)				
OPTIONAL CO	OVERAGE O ADD	O CHANG	E	DELE	ETE							
If applying for (Optional Coverage, the	e Non-Smoker Qι	estionr	naire an	d/or the	Stater	nent of Health may o	also be required	d.			
Do you use tobo	acco products? O Y	∕es O No										
Answer "No" if	you have not used any	nicotine or used	any sm	oking ce	essation p	oroduc	ets in any form (inclu	ding e-cigarette	es) in the past 12 mor	iths.		
Optional Life:	O Emp	loyee Em _l							pouse Amount \$			
Optional Depe	ndent Child Life:			Amount	\$							
Optional Critic	al Illness: O Emp	loyee Em _l	ployee .	Amount	: \$			O Spouse S	pouse Amount \$			
	O Child	d	Child	Amount	: \$							
Optional Accid	ental Death & Dismer	nberment: O E	mploye	e Only	O Em	ploye	e & 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

	First Name	Last Na	me	Percentage	Relationship	Revocable	Irrevocable
				(Must total 100%)			
						0	<u> </u>
						0	<u> </u>
						0	0
	T	1					
	First Name	Last Name	Date of Birth (DD/MM/YYYY)	Percentage (Must total 100%)	Relationship	Telephone N	umber
Contingent							
Contingent							
	ed beneficiaries considered for any beneficiary considere	a minor: I appoint d a minor under the provincial ju	risdiction of residen	ce.	as Tr	rustee to receive	e any
	rrevocable, no future change es) is/are the age of majority.	es to your beneficiary designation	n will be permitted w	vithout the written	consent of that beneficiary(ie	es) when the	
N QUEBEC,	THE DESIGNATION OF YO	UR SPOUSE AS BENEFICIARY I	S PRESUMED IRRE	VOCABLE UNLES	S OTHERWISE SPECIFIED.		
		eneficiary of a life insurance pol plicable), and not to anyone else					
erson admir	nistering the child's proceeds	, you should ensure you have the teps you can take to support you	e proper provisions i				
MARITAL C	HANGE						
		om single to family coverage witl act. If later than 31 days, a State				tlined in the	
Date of cha	nge in Marital Status (DD/MM/	/YYYY):		_			
	nge in Marital Status (DD/MM/ Is Medavie Blue Cross benef			_			
f Spouse ha	s Medavie Blue Cross benef			Last Name: _			
I f Spouse ha Policy Numb	s Medavie Blue Cross benef	its, please complete:		Last Name: _			
If Spouse had Policy Numb AUTHORIZA understand am an eligible	er: Idei ATION OF CHANGE that the personal information	its, please complete:	l and used by Medavi	e Blue Cross to ad	minister the terms of my policy c		
Policy Numb AUTHORIZA understand am an eligibl Cross Privacy Depending o	as Medavie Blue Cross beneficer: Idea ATION OF CHANGE that the personal information to be member, recommend suitable as Statement at medaviebc.ca. In the type of coverage I carry, as required for the purposes of	its, please complete: ntification Number: I have provided herein is collected	d and used by Medavi eligible for as a memb as claim, health and/ benefits outlined in t	e Blue Cross to ado per of a policy, and or financial related he policy of which I	minister the terms of my policy o other applicable purposes, as d data may be collected from an am an eligible member. These t	described in the <i>I</i> and/or released to third parties may	Medavie I following include
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Completed for Employer by: