

**1. This section to be completed by employer**

Group name	Group number	ID number	Effective date of change (YYYY-MM-DD)		
Last name		First name		Birth date (YYYY-MM-DD)	
<b>Change employment information</b>					
<input type="checkbox"/> <b>Transfer</b>	Revised section	Revised employee class			
<input type="checkbox"/> <b>Salary</b>	Complete for changes in Employee Life Insurance and disability benefits. Revised salary \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually				
<input type="checkbox"/> <b>Occupation</b>	Revised occupation				
<input type="checkbox"/> <b>Reinstatement</b>	Date returned to work (YYYY-MM-DD)				
<input type="checkbox"/> <b>Other</b>	Revised department ID	Revised other identity number	Revised hours worked per week		
<b>Complete for spending account benefits</b>					
Add <input type="checkbox"/> Change <input type="checkbox"/> Delete <input type="checkbox"/>	Health Spending Account (non-taxable)	Credit deposit date (YYYY-MM-DD)	Credit deposit amount \$	Frequency <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Annually	Payment options <input type="checkbox"/> Automatic <input type="checkbox"/> Discretionary
Add <input type="checkbox"/> Change <input type="checkbox"/> Delete <input type="checkbox"/>	Wellness Spending Account (taxable)				

**2. Change employee address, phone number or email**

Mailing address		City	Province	Postal code
Daytime phone	Home phone	Email		

**3. Change employee name or gender**

Last name	First name	Middle initial	Gender <input type="checkbox"/> M <input type="checkbox"/> F
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**4. Change spouse, common-law spouse or dependent information**

Add	Change	Delete	Last name	First name	Middle initial	Relationship	Date of marriage or cohabitation (YYYY-MM-DD)	Birth date (YYYY-MM-DD)	Gender	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Married spouse <input type="checkbox"/> Common-law			<input type="checkbox"/> M <input type="checkbox"/> F	
<b>Unmarried dependent children:</b> <input type="checkbox"/> Check this box if you have more than 4 dependents. Please write out their information on the back of this form.										
Add	Change	Delete	Last name	First name	Middle initial	Relationship	Birth date (YYYY-MM-DD)	Gender	If over the age of 21	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/> M <input type="checkbox"/> F	Full-time student	Disabled dependent
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**5. Direct deposit information**

Bank account holder's name			
Bank account numbers (the image to the right shows you where to find these numbers at the bottom of your cheque)	Cheque number    0 9 9	Transit : 0 9 9 9 9	Institution 0 9 9 1 :
Claim payments will be directly deposited into this bank account	Account 0 9    0 9 9 9 9 9 9 9 9	Transit	Account

**6. Change in coverages**

<input type="checkbox"/> <b>ADD</b> the following benefits as coverage has been terminated under my spouse's employer plan. <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Employee Family Assistance Program <input type="checkbox"/> Employee Life Insurance benefit	Termination date of spouse's coverage (YYYY-MM-DD)
<input type="checkbox"/> <b>WAIVE</b> the following benefits as coverage has been added under my spouse's employer plan. <i>I understand that if benefits have been waived, I will not be able to re-enrol for these benefits at a later date unless application occurs within 31 days of termination of my spouse's coverage.</i>  <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Employee Family Assistance Program <input type="checkbox"/> Employee Life Insurance benefit <i>Waiving of life insurance benefits is subject to your group's participation requirements.</i>	Group/policy number  Name of insurance company

**7. Coordination of benefits**

Do you have coverage through another insurance company? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please indicate below)			
Benefits covered: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Drugs			
Name of insured	Birth date of insured (YYYY-MM-DD)	Group/policy number	Name of insurance company

**8. Change in optional coverages**

Note: some optional coverages may not be applicable to your plan. If applicable, Alberta Blue Cross will round to the nearest dollar that your plan allows for. This information can be found in your benefit booklet. For spouse and child lines of Optional Life, Optional Critical Illness and Optional Accidental Death and Dismemberment, the beneficiary will be the employee.

<b>Optional Life</b>  Add   Change   Delete <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Employee amount \$ _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spouse amount   \$ _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Child amount   \$ _____	<b>Optional Critical Illness</b>  Add   Change   Delete <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Employee amount \$ _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spouse amount   \$ _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Child amount   \$ _____	<b>Optional Accidental Death and Dismemberment</b> <i>Dependent amounts will be calculated as specified in your benefit booklet.</i>  Add   Change   Delete <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Amount \$ _____
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**9. Acknowledgment and consent**

I authorize Alberta Blue Cross, Blue Cross Life Insurance Company of Canada\* and/or its agents or affiliates to collect, use, maintain and disclose personal information for the purposes of determining eligibility for coverage, assessment, paying claims, audit, investigation, underwriting, administration and claim management. I acknowledge and agree that my personal information may only be collected from and/or released to a third party (health care professional/practitioner/insurer or reinsurer/agent of record/my employer) only when needed for a purpose stated above. I confirm that I am authorized by my spouse and dependents to receive and disclose information about them that is used solely for these purposes.

I understand that I can revoke this consent at any time in writing; however, if consent is withheld or revoked, coverage may be denied or rescinded. I understand why I have been asked to disclose this information and am aware of the risks and benefits of consenting, or refusing to consent, to the disclosure. I agree that this consent shall be effective on the date of this application and shall be valid for the duration of the time coverage is in effect. I agree that a copy or electronic version of this authorization shall be as valid as the original.

For a copy of our privacy policies, or questions about our personal information policies and practices, please refer to [ab.bluecross.ca](http://ab.bluecross.ca) or email our privacy compliance officer at [privacy@ab.bluecross.ca](mailto:privacy@ab.bluecross.ca).

By choosing to have direct deposit, I hereby authorize Alberta Blue Cross to deposit claims payments as indicated. By providing my email, I understand that I will no longer receive paper statements and instead I will receive an email notice when my statement has been posted to the member site. I understand that the direct deposit information and email address provided above will apply to all Alberta Blue Cross plans of which I am a member. Please do not email this form back to us, as email is not considered a secure form of transmission.

I certify that all the information on this form is true and complete and I acknowledge that all other Alberta Blue Cross coverage that I may have in place will remain active.

Employee signature

Date (YYYY-MM-DD)

**FORM SUBMISSION**

**EMPLOYEE:**

**Please submit this to your plan administrator.**

**Please do not email this form, as email is not considered a secure method of communication.**

**PLAN ADMINISTRATOR:**

**Please input this form's information or upload this form to the plan administrator website.**

**Please do not email this form, as email is not considered a secure method of communication.**

*If you do not have access to the plan administrator site, email [groupeligibility@ab.bluecross.ca](mailto:groupeligibility@ab.bluecross.ca) or call 780-498-5925 or 1-866-498-5925 (toll free) to request access.*

You can also mail or fax this form to Alberta Blue Cross using the contact information found at the top of this form.

