# BLUE CROSS®

# CHANGE FORM

516 2nd Avenue North, PO Box 4030
Saskatoon SK S7K 3T2
www.sk.bluecross.ca

**Instructions:**

1) Earnings information is only required if life and/or disability income benefits apply.
2) Employer to forward original and keep second copy, **EXCEPT** when completing Change of Beneficiary - send both. In this instance the Form will be recorded and one copy will be returned to the employer.
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).

**THIS AREA MUST BE COMPLETED FOR CHANGES TO BE PROCESSED**

EXISTING IDENTIFICATION NUMBER _____

EXISTING POLICY NUMBER _____

LAST NAME _____

Please print in ink or type information

## TYPE OF CHANGE - CHECK (✓)

☐ Address ☐ Marital Status ☐ Beneficiary ☐ Left Employ ☐ Other _____
☐ Telephone No. ☐ Salary ☐ Benefits ☐ Deceased _____
☐ Dependent(s) ☐ Occupation ☐ Retired ☐ Transfer _____

## COMPLETE ONLY AREAS AFFECTED BY THE CHANGE AND SIGN

Employee Last Name

Address (Street & No.)

City or Town Province

Postal Code | Telephone No. ( )

| FIRST NAME | INITIAL | SEX M/F | BIRTH DATE Day | Mo. | Yr. | Dependent Status | A - Add C - Change D - Delete |
|---|---|---|---|---|---|---|---|
| Employee | | | | | | E - Student (College/ University) S - Disabled | |
| Spouse | | | | | | | |
| Children | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

## WAIVER OF BENEFITS

I have been given the opportunity to apply for coverage but do not wish to participate, and understand that I will not be able to enroll in these plans at a later date without the consent of my employer and Saskatchewan Blue Cross.

☐ WAIVE ONLY _____

☐ WAIVE ALL BENEFITS

REASON _____

## STATUS CHANGE

☐ Single ☐ Family

## TYPE OF STATUS CHANGE (✓)

☐ Marriage ☐ Cohabitation

DATE OF MARRIAGE/COHABITATION _____ Day _____ Month _____ Year

IF SPOUSE HAS OTHER COVERAGE PLEASE COMPLETE COORDINATION OF BENEFITS SECTION

## COORDINATION OF BENEFITS

Do you or any of your dependents have other coverage under any other insurer?

☐ Yes ☐ No

If Yes, complete the following:

Coverage Effective Date: _____

Name of the Other Insurer: _____

Policy No.: _____ ID No.: _____

Type of Coverage: ☐ Health ☐ Dental ☐ Other _____

Name of the Cardholder of other coverage: _____

Covered Insureds: ☐ All ☐ Spouse ☐ Specific Insureds _____

## OPTIONAL COVERAGES

☐ ADD ☐ CHANGE ☐ DELETE (Complete Optional Group Life Insurance Statement of Health form for coverage)

**Life** (state total amt) Employee $ _____ Spouse $ _____

☐ Smoker ☐ Smoker
☐ Non-Smoker ☐ Non-Smoker

☐ ADD ☐ CHANGE ☐ DELETE

**AD&D** (state total amt) ☐ Single ☐ Family $ _____

## BASIC COVERAGE

☐ ADD ☐ CHANGE ☐ DELETE

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

## 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.

| | Beneficiary Last Name | First Name | Initial | Relationship | Percentage |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |

## TRUSTEE DESIGNATION FOR BENEFICIARY UNDER AGE 18 (Complete only if beneficiary is under age 18)

Surname of Trustee First Name Middle Initial

I hereby appoint the trustee named here to receive any amount due my beneficiary under age 18 and authorize such trustee to spend all or any portion of such amount and the income from it for the maintenance and education of such minor.

## AUTHORIZATION OF CHANGE

I certify that all information contained herein is correct and hereby authorize payroll deductions, if required, for the changes specified. I have read the Authorization and Consent on the reverse of this form.

Employee's 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 Income Replacement | Occupation |
|---|---|---|---|---|
| | | | | |

| Effective Date of Change Day | Mo. | Yr. | Complete for Life and Income Replacement Benefits | Hours Worked Per Week | Payroll No. (maximum 9 positions) | Completed for Employer by |
|---|---|---|---|---|---|---|
| | | | Earnings Per ☐ Hour ☐ Month ☐ Week ☐ Year $_____ | | (1) _____ (2) _____ | _____ Signature _____ Date |

## AGREEMENT & CONSENT CLAUSE

I, the undersigned, declare that the answers to the above questions are complete and accurate and form part of an application for coverage with Saskatchewan Blue Cross and/or Blue Cross Life Insurance Company of Canada. I understand that any injury that occurred on or before the date of this application or any sickness, the signs of which appeared on or before the date of this application, will not be covered unless fully disclosed on this application. The discovery of facts known by me or my eligible dependents but not stated in this application could result in the cancellation or modification of coverage or the denial of a claim. All information provided herein and collected in the future as part of the application process will be used to determine eligibility for coverage and will be kept confidential and secure.

I understand that the personal information provided herein as well as any other personal information currently held or collected in the future by Saskatchewan 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 develop and recommend suitable products and services to me and to manage the Company'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 include other Blue Cross organizations, licensed physicians and/or any other healthcare professionals or institutions, health and life insurers, government and regulatory authorities, and other third parties when required to administer the benefits outlined in my policy or the group 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, if consent is withheld or revoked, coverage may be denied or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding the privacy policies of Blue Cross and/or the collection, use or disclosure of my personal information, I can visit www.sk.bluecross.ca or call 1-800-USEBLUE®.

*A photocopy of this authorization shall be as valid as the original. This consent complies with federal and provincial privacy laws.*