

THIS AREA MUST BE COMPLETED FOR CHANGES TO BE PROCESSED

Existing ID Number: _____

Existing Policy Number: _____

Last Name: _____

TO BE COMPLETED BY EMPLOYER - COMPLETE ONLY AREAS AFFECTED BY CHANGE

Name of Employer: _____ Effective Date of Change: _____

Class: _____ Division #: _____

Occupation: _____

Change to Payroll I.D. Number: _____

Complete for Life & Income Replacement Benefits:
Earnings: \$ _____
 Hourly Weekly
 Monthly Yearly
Hours Worked per Week: _____

Completed for Employer by: _____
Signature Date (YYYY/MM/DD)

COMPLETE ONLY AREAS AFFECTED BY CHANGE AND SIGN

Last Name _____ First Name _____

Address _____

City _____ Province _____ Postal Code _____

Email Address _____

Phone Number _____ Home Work Mobile

| | First & Last Name | Birth Date (YYYY/MM/DD) | Sex M/F | Dependent Status | A - Add C - Change D - Delete |
|----------|-------------------|-------------------------|---------|--|-------------------------------------|
| Employee | | | | E - Student (College/University) S - Disabled | |
| Spouse | | | | | |
| Children | | | | | |
| | | | | | |

BASIC COVERAGE

Add Change Delete

Life AD&D Health

Weekly Indemnity Dental Dependent Life

Critical Condition Long Term Disability

WAIVER OF BENEFITS

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

Waive ALL Benefits Waive Only: _____

OPTIONAL COVERAGES

Add Change Delete

(Medical Underwriting is required.)

Life (state total amt in units of \$10,000) Employee \$ _____
Spouse \$ _____

Add Change Delete

AD&D (state total amt in units of 10,000) \$ _____

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 Acknowledgment and Consent on Page 2 of this form.**

Signature _____

Date (YYYY/MM/DD) _____

PLEASE REFER TO ACKNOWLEDGMENT AND CONSENT ON PAGE 2.

STATUS CHANGE

Type of Status Change: Marriage Cohabitation Cohabitation
Date of Marriage/Cohabitation: _____
DD/MM/YYYY

If spouse has other coverage please complete **COORDINATION BENEFITS SECTION.**

COORDINATION OF BENEFITS

Do you or any of your dependents have alternate Health and/or Dental coverage?

Yes No **If Yes, please complete the following:**

Name of Other Insurer _____ Policy No. _____ I.D. Number _____

Coverage Effective Date (YYYY/MM/DD) _____ Name of Cardholder of other coverage _____

Type of Coverage: Health Dental Other: _____

Covered Insureds: All Spouse Specific Insureds: _____

BENEFICIARY DESIGNATION

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 (in equal shares, unless otherwise designated).

| Beneficiary Last Name | First Name | Age | Relationship | Percentage |
|-----------------------|------------|-----|--------------|------------|
| | | | | % |
| | | | | % |
| | | | | % |

TRUSTEE DESIGNATION (COMPLETE IF BENEFICIARY IS UNDER AGE 18):

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.

Last Name _____ First Name _____



ACKNOWLEDGMENT & CONSENT

I understand that the personal information I have given, as well as any other personal information currently held or provided in the future by Saskatchewan Blue Cross, Blue Cross Life Insurance Company of Canada and/or its agents may be collected, used, maintained and disclosed for the purposes of determining eligibility for coverage, underwriting, administering products and services, audit and investigation, confirming my identity, maintaining my relationship with Saskatchewan Blue Cross, and to help develop and recommend suitable products and services to me.

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, and/or their authorized agents/brokers, representatives, licensed physicians, practitioners or other healthcare providers, hospitals, clinics or other medical facilities, other health and life insurers and reinsurers, MIB, Inc., employers (past and present) government and regulatory authorities, and other third parties only when needed for a purpose stated above.

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.