SASKATCHEWAN BLUE CROSS®

516 2nd Avenue North, PO Box 4030
Saskatoon, SK S7K 3T2

CHANGE FORM

GRPA 1004

Complete relevant areas of the form and return to your Plan Administrator for completion and submission.

THIS AREA MUST BE COMPLETED FOR CHANGES TO BE PROCESSED

Existing ID #: _____

Existing Policy #: _____

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 ID 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

Street Address

City/Town Province Postal Code

Email Address

☐ Home ☐ Work ☐ Mobile

Phone Number

	Name (First and last)	Birth Date (YYYY-MM-DD)	Sex* M/F/ I/U	Dependent Status	A - Add C - Change D - Delete
Employee				E - Student (College/ University) S - Incapacitated	
Partner					
Children					

***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 your sex may differ from your gender identity.

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 $_____

Partner $ _____

☐ 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 THE ACKNOWLEDGMENT AND CONSENT ON PAGE 2.

STATUS CHANGE

Type of Status Change:

☐ Marriage ☐ Cohabitation

Date of Marriage/ Cohabitation: _____ (YYYY-MM-DD)

If partner has other coverage, please complete the **COORDINATION OF 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 Cardholder Date of Birth (YYYY-MM-DD)

Other Insurer Policy No. ID Number Coverage Effective Date (YYYY-MM-DD)

Type of Coverage: ☐ Health ☐ Dental ☐ Other: _____

Covered Insureds: ☐ All ☐ Partner ☐ 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).

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.

Trustee Full Name Phone Number

ACKNOWLEDGMENT & CONSENT

I declare that the answers to the questions on this form are complete and accurate.

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, adjudicating and paying claims, administering products and services, audit and investigation, confirming my identity, maintaining my relationship with Saskatchewan Blue Cross and helping to 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/representatives, licensed physicians, practitioners or other healthcare providers, hospitals, clinics or other medical facilities, other health and life insurers and reinsurers, MIB, LLC, 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 in writing; 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 Saskatchewan Blue Cross and/or the collection, use or disclosure of my personal information, I can visit www.sk.bluecross.ca or call 1.800.667.6853.
A photocopy of this authorization shall be as valid as the original.