ALBERTA BLUE CROSS®

SHADED AREA FOR BLUE CROSS USE ONLY

EMPLOYEE BENEFITS APPLICATION

10009-108 Street NW, Edmonton, Alberta T5J 3C5

Telephone: (780) 498-8100 or 1-800-232-1914
Fax: (780) 498-8532 www.ab.bluecross.ca

1. THIS SECTION TO BE COMPLETED BY EMPLOYEE

SURNAME	GIVEN NAME AND MIDDLE INITIALS	EMPLOYEE DATE OF BIRTH: YYYY MM DD
STREET ADDRESS	CITY / TOWN	PROVINCE / POSTAL CODE
HOME TELEPHONE ( ) WORK TELEPHONE ( )	GENDER ☐ Male ☐ Female	BENEFIT STATUS ☐ Single ☐ Family / PROVINCIAL HEALTH NUMBER

2. PLEASE COMPLETE THIS SECTION FOR FAMILY COVERAGE

☐ Spouse ☐ Common law — SURNAME (If different than employee's) — GIVEN NAME AND MIDDLE INITIALS — GENDER ☐ M ☐ F — DATE OF BIRTH YYYY MM DD — PROVINCIAL HEALTH NUMBER — Date of Common Law Cohabitation YYYY MM DD

UNMARRIED DEPENDENT CHILDREN: (NOTE: If additional space is required please use the back of this page)

SURNAME (If different than employee's)	GIVEN NAME AND MIDDLE INITIALS	RELATIONSHIP	GENDER	DATE OF BIRTH YYYY MM DD	PROVINCIAL HEALTH NUMBER	*CODE (See below)
			☐ M ☐ F			
			☐ M ☐ F			
			☐ M ☐ F			

***CODES:** A = An unmarried, fully dependent child less than the dependent age as specified in the booklet.
B = An unmarried child over the dependent age but under the maximum age specified in the booklet. This dependent must be attending an accredited educational institution on a full-time basis. **NOTE**: Please enter the date school commences beside all code B dependents. An annual *Dependency Declaration* is required for each school year.
C = An unmarried child, over the dependent age as specified in the booklet, but fully dependent on me due to mental or physical infirmity.

3. PLEASE COMPLETE THIS SECTION IF YOU ARE WAIVING BENEFITS

I am waiving the following benefits as I am currently covered through my spouse's plan: ☐ **Health** ☐ **Dental**
Group Number — Name of insurance company

I understand that if benefits have been deleted, I will not be able to re-enrol for these benefits at a later date unless application occurs within 31 days of termination of spousal coverage.

I wish to waive the following, subject to the group contract participation requirements:
☐ **All Life & Disability Benefits**

4. COORDINATION OF BENEFITS

Do you have coverage through another insurance company? ☐ No ☐ Yes - **If yes, please indicate:**
Name of Insured — Name of insurance company — Group Number

Benefits Covered: ☐ Health ☐ Dental ☐ Vision ☐ Drugs

5. OPTIONAL COVERAGES APPLIED FOR

☐ **OPTIONAL LIFE** (must be in units of $10,000) ☐ Employee Amount: $ ☐ Spouse Amount: $

☐ **OPTIONAL AD&D** $
☐ Employee
☐ Employee & Eligible Dependents

***NOTE:** For Dependent Life, Optional Life and Optional AD&D the employee is the beneficiary of the insured spouse and children.*

6. BENEFICIARY FOR LIFE BENEFITS

Beneficiary's Surname	First Name	Middle Initial(s)	Relationship	**Percentage** (Total must = 100%)
1				
2				
3				

For designated beneficiaries who are minors I wish to appoint: **as Trustee to receive any amount due for any beneficiary considered a minor under the Provincial jurisdiction of residence.**

Contingent Beneficiary: I wish to appoint: in the event **ALL** noted Beneficiaries are deceased.

7. ACKNOWLEDGEMENTAND CONSENT

I certify that all the above information is true and complete and agree to the Acknowledgement and Consent on the reverse side of this form.

Employee Signature: Date:

THIS SECTION TO BE COMPLETED BY EMPLOYER

NAME OF GROUP	GROUP AND SECTION NUMBER	REQUESTED EFFECTIVE DATE OF COVERAGE: YYYY MM DD
DEPARTMENT	EMPLOYEE NUMBER / OTHER IDENTITY NUMBER / OCCUPATION / HOURS WORKED / WEEK	**DATE OF HIRE:** YYYY MM DD ☐ Full Time ☐ Part Time
COMPLETE FOR LIFE AND DISABILITY BENEFITS	EMPLOYEE CLASS:	EARNINGS: $ Per: ☐ Hour ☐ Week ☐ Month ☐ Year
I hereby certify this employee meets the contractual requirements outlined in the group contract.	**COMPLETED FOR EMPLOYER BY**	DATE / TELEPHONE & AREA CODE

FOR BLUE CROSS USE ONLY	PROV.	STATUS	TYPE OF APP.	MODE OF EARN.	OCCUPATION	LANG.	EMP. CLASS - Life	EFFECTIVE DATE YYYY MM DD	SP. RATING CODE	OCCUPATION CODE WI CCB LTD	BENEFICIARY CODE	DLIF CODE
	7					E			N			

GROUP, SECTION AND COVERAGE NUMBER | BENEFIT STATUS / DATE PROCESSED | SCREEN 51-55 ☐ | SCREEN 53 ☐ LIFELINK "1" VAD&D ☐ OPTIONAL LIFE | EMP _____ SP _____

ABC 20057 (R04/2004)

Blue Cross Life Insurance Company of Canada underwrites all life and income replacement benefits.

ACKNOWLEDGEMENT AND CONSENT

I certify that the information provided on this form is true and complete. I understand that the personal information provided herein as well as other personal information currently held or collected in the future by Alberta Blue Cross and/or Blue Cross Life Insurance Company of Canada* may be collected, used or disclosed to administer the terms of my policy and to manage the Company's business. Limited personal information may be collected from and/or released to a third party for the purposes listed above. This may include: a licensed physician and/or other healthcare professional or institution, another Blue Cross organization, a health and life insurer, government or regulatory authority or other third party when required to administer the benefits outlined in my policy.

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, the 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 Blue Cross privacy policies, I can contact Alberta Blue Cross at (780) 498-8100, ext. 8108 (privacy@ab.bluecross.ca) should I have questions as to the collection, use of or disclosure of my personal information. I authorize Alberta Blue Cross and/or Blue Cross Life Insurance Company of Canada to collect, use and disclose my personal information as described.

*Blue Cross Life Insurance Company of Canada underwrites all life and income replacement benefits.