

EMPLOYEE BENEFITS APPLICATION

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

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1. THIS SECTION TO BE COMPLETED BY EMPLOYEE

SURNAME		GIVEN NAME AND MIDDLE INITIALS			EMPLOYEE DATE OF BIRTH:	YYYY	MM	DD
MAILING ADDRESS				CITY / TOWN	PROVINCE	POSTAL CODE		
HOME TELEPHONE () ()	WORK TELEPHONE () ()	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	BENEFIT STATUS <input type="checkbox"/> Single <input type="checkbox"/> Family		PROVINCIAL HEALTH NUMBER			

2. PLEASE COMPLETE THIS SECTION FOR FAMILY COVERAGE

<input type="checkbox"/> Spouse	SURNAME (If different than employee's)	GIVEN NAME AND MIDDLE INITIALS	GENDER	DATE OF BIRTH	PROVINCIAL HEALTH NUMBER	Date of Common Law Cohabitation
<input type="checkbox"/> Common law			<input type="checkbox"/> M <input type="checkbox"/> F	YYYY MM DD		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	PROVINCIAL HEALTH NUMBER	*CODE
			<input type="checkbox"/> M <input type="checkbox"/> F	YYYY MM DD		(See below)
			<input type="checkbox"/> M <input type="checkbox"/> F			
			<input type="checkbox"/> M <input type="checkbox"/> 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 Employee Benefits Booklet, but fully dependent on me due to mental or physical disability.

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: <input type="checkbox"/> Health <input type="checkbox"/> Dental		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: <input type="checkbox"/> All Life & Disability Benefits
Group Number	Name of insurance company		

4. COORDINATION OF BENEFITS

Do you have coverage through another insurance company? <input type="checkbox"/> No <input type="checkbox"/> Yes - If yes, please indicate:	Name of Insured	Name of insurance company	Group Number	Benefits Covered:
				<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Drugs

5. OPTIONAL COVERAGES APPLIED FOR

<input type="checkbox"/> OPTIONAL LIFE (must be in units of \$10,000)	<input type="checkbox"/> Employee Amount: \$	<input type="checkbox"/> Spouse Amount: \$	<input type="checkbox"/> OPTIONAL AD&D	\$	NOTE: For Dependent Life, Optional Life and Optional AD&D the employee is the beneficiary of the insured spouse and children.
			<input type="checkbox"/> Employee <input type="checkbox"/> Employee & Eligible Dependents		

6. BENEFICIARY FOR LIFE BENEFITS (NOTE: If additional space is required please use the back of this page.)

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

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. ACKNOWLEDGEMENT AND 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. I acknowledge that all other Alberta Blue Cross coverage that I may have in place will remain active.

Employee Signature: _____ Date: _____

THIS SECTION TO BE COMPLETED BY EMPLOYER

NAME OF GROUP				GROUP AND SECTION NUMBER		EFFECTIVE DATE OF COVERAGE: YYYY MM DD		
DEPARTMENT	EMPLOYEE NUMBER	OTHER IDENTITY NUMBER	OCCUPATION	HOURS WORKED / WEEK		DATE OF HIRE: YYYY MM DD		
						<input type="checkbox"/> Permanent Full Time <input type="checkbox"/> Permanent Part Time		
COMPLETE FOR LIFE AND DISABILITY BENEFITS		EMPLOYEE CLASS:	EARNINGS: \$	Per:	<input type="checkbox"/> Hour	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> 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. 7	STATUS	TYPE OF APP.	MODE OF EARN.	OCCUPATION	LANG. E	EMP. CLASS - Life	EFFECTIVE DATE YYYY MM DD	SP. RATING CODE N	OCCUPATION CODE WI CCB LTD	BENEFICIARY CODE	DLIF CODE
	GROUP, SECTION AND COVERAGE NUMBER				BENEFIT STATUS / DATE PROCESSED		SCREEN 51-55	SCREEN 53 LIFELINK "1" VAD&D	<input type="checkbox"/> OPTIONAL EMP LIFE SP			

ACKNOWLEDGEMENT AND CONSENT

I certify that the information contained on this form is true and complete. I understand that the personal information provided herein about me and eligible dependents, 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 used or disclosed only to determine eligibility for benefits; verify, assess and pay claims; administer the terms of my benefit plan and policy and to manage the Company's business. I certify that I am authorized by my spouse and/or other adult dependents to disclose and receive information about them that is used solely for these purposes.

I hereby acknowledge and agree that my/my dependents' personal information may be exchanged between only Alberta Blue Cross and a licensed physician and/or other health care professional, institution or health benefits provider or insurer or government or regulatory authority and only as needed for a purpose stated above.

I understand that my and my dependents' personal information will be kept confidential and secure. I understand that I may revoke this consent at any time and acknowledge that should I do so, the coverage may be denied or rescinded. I understand why my/my dependents' personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its use as described above.

I have read and understood this Acknowledgement and Consent and authorize Alberta Blue Cross to collect, use and disclose my/my dependents' personal information as described above. This consent shall be effective from the date of signature of this form and shall remain in effect as long as the coverage is in force.

For additional information regarding Alberta Blue Cross privacy policies, visit www.ab.bluecross.ca or contact Alberta Blue Cross at (780) 498-8100 ext. 8108.

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