



The strength you need. The care you deserve.

644 MAIN ST PO BOX 220 7 SPECTACLE LAKE DR DARTMOUTH
 MONCTON NB E1C 8L3 PO BOX 2200 HALIFAX NS B3J 3C6
 FOR ALL INQUIRIES: TEL 1-800-667-4511 FAX (506) 867-4651

CHANGE FORM

Instructions:

- Earnings information is only required if life and/or income replacement benefits apply.
- Employer to forward original and keep second copy.
- 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 _____

TYPE OF CHANGE - CHECK (✓)

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

COMPLETE ONLY AREAS AFFECTED BY THE CHANGE AND SIGN

Employee Last Name	FIRST NAME	INITIAL	Surname (if different from applicant)*	SEX M/F	BIRTH DATE DD MM YY			Dependent Status	A-Add C-Change D-Delete
Address (Street & No.)	Employee							E- Student (College/ University) S-Disabled	
	Spouse								
	Children								
City or Town									
Province	Telephone No. ()								
Postal Code	Language Preferred <input type="checkbox"/> English <input type="checkbox"/> French			* IF APPLICANT AND SPOUSE ARE NOT LEGALLY MARRIED, PLEASE PROVIDE COMMENCEMENT DATE OF CO-HABITATION _____					

COORDINATION OF BENEFITS

Do you or any of your dependents have other coverage under any other Insurer? Yes No **If Yes, complete the following:**

Name of the Other Insurer: _____ Effective Date of Coverage: _____

Identification Number/Certificate Number: _____ Policy Number: _____

Is the Coordination of Benefits Single Coverage or Family Coverage? Please indicate under "Type of Coverage" S for Single or F for Family for the applicable benefits.

Type of Coverage: All _____ Hospital _____ Extended Health Benefits _____ Vision _____ Drugs _____ Dental _____

BASIC COVERAGE <input type="checkbox"/> ADD <input type="checkbox"/> CHANGE <input type="checkbox"/> DELETE <input type="checkbox"/> Life <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Dependent Life <input type="checkbox"/> Health <input type="checkbox"/> AD & D <input type="checkbox"/> Weekly Indemnity <input type="checkbox"/> Dental <input type="checkbox"/> Critical Conditions	STATUS CHANGE <input type="checkbox"/> Single <input type="checkbox"/> Family	OPTIONAL COVERAGES <input type="checkbox"/> ADD <input type="checkbox"/> CHANGE <input type="checkbox"/> DELETE Life (state total amt.) Employee \$ _____ Spouse \$ _____ AD&D (state total amt.) <input type="checkbox"/> Single <input type="checkbox"/> Family \$ _____ Dependent Child Life <input type="checkbox"/> YES <input type="checkbox"/> NO
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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. _____	_____	_____	_____	_____

MARITAL CHANGE - When an employee requests a change from single to family coverage within 31 days of marriage, family coverage will become effective as outlined in the Atlantic Blue Cross Care group benefits contract. If later than 31 days, a statement of health may be required.

Date of change in marital status: **If spouse has Atlantic Blue Cross Care benefits please complete:**

DD MM YY Policy Number Identification Number Last Name

AUTHORIZATION OF CHANGE - I certify that all information contained hereon is correct and hereby authorize payroll deductions, if required, for the changes specified.

Employee Signature _____ Witness 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 Disability Income	Occupation
Effective Date of Change DD MM YY		Complete for Life and Disability Income Benefits Earnings Per <input type="checkbox"/> Hour <input type="checkbox"/> Month <input type="checkbox"/> Week <input type="checkbox"/> Year \$ _____	Hours Worked Per Week	Payroll No. (maximum 9 positions) (1) _____ (2) _____	Completed for Employer by Signature _____ Date _____	