BLUE CROSS®

P.O. BOX 1046, WINNIPEG, MAN. R3C 2X7
TEL: (204) 775-0161 FAX: (204) 774-1761

CHANGE FORM

THIS AREA MUST BE COMPLETED FOR CHANGES TO BE PROCESSED

CONTRACT NUMBER _____

GROUP NUMBER _____

NAME _____

Instructions:

1) Earnings information is only required if life and/or income replacement benefits apply.
2) **Employer to forward original and keep second copy.**
3) 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).

TYPE OF CHANGE - CHECK (✓)

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

COMPLETE ONLY AREAS AFFECTED BY THE CHANGE AND SIGN

Employee's Last Name

Address (Street or Box Number)

City or Town | Province

Postal Code | Telephone No. ( )

FULL NAME	GENDER M/F	BIRTH DATE Day	Mo.	Yr.	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
❑ Dependent Life
❑ Weekly Indemnity
❑ Long Term Disability
❑ Critical Conditions

❑ * Health
❑ * Dental
❑ * Travel
❑ * Employee Assistance

* May not opt out unless there is spousal Group coverage

OPTIONAL COVERAGES

❑ ADD ❑ CHANGE ❑ DELETE

Life (state total amt.) Employee $_____ Spouse $_____
AD&D (state total amt.) ❑ Single ❑ Family $_____
Dependent Child Life ❑ YES ❑ NO

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.					
4.					

Employee's Signature _____ Date _____

MARITAL CHANGE

❑ Legal Date of Marriage ____ Day ____ Month ____ Year

❑ Common-Law Commencement Date of Co-Habitation ____ Day ____ Month ____ Year

❑ Separation/Divorce Date of ____ Day ____ Month ____ Year

If Spouse has Blue Cross Coverage Please Complete _____ Group No. _____ Contract No. _____ Last Name

Any change not received within 31 days will be subject to the current underwriting practices of Blue Cross.

AUTHORIZATION OF CHANGE

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

_____ Employee's Signature _____ Date

TO BE COMPLETED BY EMPLOYER

Name of Employer	Group and Roll Number	Employee Class - Life and/or Disability Income	Occupation

Date of Change Day	Mo.	Yr.	Complete for Life and Disability Income Benefits	Hours Worked Per Week	Payroll No. (maximum 9 positions)	Completed for Employer by
			Earnings Per ❑ Hour ❑ Month ❑ Week ❑ Year $_____			_____ Signature _____ Date