ALBERTA BLUE CROSS®

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

SHADED AREA FOR BLUE CROSS USE ONLY

HEALTH & DENTAL BENEFIT APPLICATION

Telephone: (780) 498-8100 or 1-800-232-1914
Fax: (780) 498-3540 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
MAILING ADDRESS	CITY / TOWN	PROVINCE / POSTAL CODE
HOME TELEPHONE AREA CODE ( ) / WORK TELEPHONE AREA CODE ( )	GENDER ☐ Male ☐ Female / BENEFIT STATUS ☐ Single ☐ Family	PROVINCIAL HEALTH NUMBER

2. PLEASE COMPLETE THIS SECTION FOR FAMILY COVERAGE

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

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			
			☐ 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 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: ☐ 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.

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. 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 ☐ Permanent Full Time ☐ Permanent Part Time
I hereby certify this employee meets the contractual requirements outlined in the group contract.	COMPLETED FOR EMPLOYER BY	DATE / TELEPHONE & AREA CODE ( )

BLUE CROSS USE ONLY	GROUP, SECTION AND COVERAGE NUMBER	BENEFIT STATUS / DATE PROCESSED	STATUS	EFFECTIVE DATE YYYY MM DD

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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, may be used or disclosed only to determine eligibility for benefits; verify, assess and pay claims and administer the terms of my benefit plan. 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 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.