

644 MAIN ST PO BOX 220 MONCTON NB E1C 8L3 TEL: 1-800-667-4511 FAX: 1-506-869-9653

230 BROWNLOW AVE DARTMOUTH PO BOX 2200 HALIFAX NS B3J 3C6 TEL: 1-800-667-4511 FAX: 1-506-869-9653

PO BOX 2000, 185 THE WEST MALL SUITE 1200 ETOBICOKE ON M9C 5P1 TEL: 1-800-355-9133 FAX: 1-506-869-9653

550 SHERBROOKE ST WEST, SUITE L-15 MONTREAL QC H3A 6T6 TEL: 1-888-588-1212 FAX: 1-514-286-8444

Instructions:

1) Earnings information is only required if life and/or income replacement benefits apply.
2) The Optional Group Life Insurance Statement of Health and Smoking Questionnaires must be completed when an ADD or CHANGE is requested for Optional Life or Optional Critical

•				Payroll Number:						
Existing Policy and Se	ection Number:			Last Name:						
TYPE OF C	HANGE - CHECK (√) −								
O Address	O Marital Status	OBeneficiary	O Left Employ	O Cancel Benefits: Reas	on					
O Dependent(s)	O Retired	○ Telephone No. ○ Salary ○ Add Benefits: Reason								
O Benefits	O Deceased	Occupation O Transfer O Other:								
2 COMPLET	TE ONLY AREAS	AFFECTED BY	THE CHANGE	AND SIGN						
Employee First Na	ame:		En	nployee Last Name:						
Address (Street &	Number):									
City/Town:	pwn: Province:									
Date of Birth:		·	Telephone Numbe	er:		Language Preferred: O Er	nglish O Frenc			
Spouse (if applic	able) O ADD	O CHANGE	O DELETE							
First Name:			Middle Initial	: Last Nan	ne:					
Gender: O Male	O Female			Birth Date (DD/MM/YYYY):					
	d O Common-Lav	w Date of co-h	nabitation if comm	on-law (DD/MM/YYYY):						
<u> </u>	ren (if applicable)	1	4 NI	Data of Birth	Candar	Dependent Status	A - Add			
First	Name	Las	st Name	Date of Birth (DD/MM/YYYY)	Gender M/F	Dependent Status	C - Change D - Delete			
					O Male	O Disabled	24.26.2			
					O Female	O Student - College/University	, 333			
					O Male	O Disabled				
					O Female	O Student - College/University	y OA OC O			
OTHER COVERA	GE (CO-ORDINATI	ON OF BENEFITS	S) O ADD	O CHANGE O D		Student - College/UniversitDisabled	04.00.0			
Do you or any of y Name of the Othe Policy Number:	our dependents hav r Insurer:ID	ve coverage under	any other Plan?	O Yes O No If You	O Female O Male O Female ELETE es, Complete Date of Cov	Student - College/UniversitDisabled	OA OC O			
Do you or any of y Name of the Othe Policy Number: Name of Employe	our dependents hav r Insurer:ID	ve coverage under	any other Plan?	Yes O No If Y Effective Type of Coverage: O I	O Female O Male O Female ELETE es, Comple Date of Cov	Student - College/Universit Disabled Student - College/Universit te the following: /erage (DD/MM/YYYY): Vision DEHB Drugs	OA OC O			
Do you or any of y Name of the Othe Policy Number: Name of Employe	our dependents hav	ve coverage under	, any other Plan? Date of Birth	Yes O No If Y Effective Type of Coverage: O I	O Female O Male O Female ELETE es, Comple Date of Cov	Student - College/Universit Disabled Student - College/Universit te the following: Verage (DD/MM/YYYY): Vision O EHB O Drugs	O Dental O Date of Birth			
Do you or any of y Name of the Othe Policy Number: Name of Employe Name of Person BASIC COVERAG O Life O Lor	your dependents have represented in the results of	O CHANGE O Dependent Led if you indicate fa	Date of Birth D MM YYY DELETE ife O Health mily status and el	Yes O No If Y Effective Type of Coverage: O I Name of Person(s	O Female O Male O Female ELETE es, Comple Date of Cov	Student - College/Universit Disabled Student - College/Universit te the following: Verage (DD/MM/YYYY): Vision	O Dental O			
Do you or any of y Name of the Othe Policy Number: Name of Employe Name of Person BASIC COVERAG Life	your dependents have r Insurer: ID or: (s) insured under other GE	O CHANGE O Dependent Led if you indicate fa	Date of Birth D MM YYY DELETE ife	Name of Person(s AD & D igible dependents.	Female Male Female ELETE es, Comple Date of Cov Hospital insured unc	Student - College/Universit Disabled Student - College/Universit te the following: Verage (DD/MM/YYYY): Vision	O Dental O Date of Birth MM YYYY			
Do you or any of y Name of the Othe Policy Number: Name of Employe Name of Person BASIC COVERAG O Life O Lor Dependent life is a O HCSA Allocation STATUS CHANG	GE ADD ng Term Disability automatically include n \$ E Single ERAGE ADI	O CHANGE O Dependent Led if you indicate fa	Date of Birth D MM YYY O DELETE ife O Health amily status and el O PSA A	Name of Person(s AD & D igible dependents. Illocation \$	Female Male Female ELETE es, Complet Date of Cov Hospital insured unc	Student - College/Universit Disabled Student - College/Universit te the following: Verage (DD/MM/YYYY): Der other policy DD mnity Dental	O Dental O Date of Birth MM YYYY O Critical Illness			
Do you or any of y Name of the Othe Policy Number: Name of Employe Name of Person BASIC COVERAG O Life O Lor Dependent life is a O HCSA Allocation STATUS CHANGI OPTIONAL COVE Optional Life:	ge ADD ng Term Disability automatically include n \$ E Single ERAGE ADD C Single C Emplo	O CHANGE O Dependent Led if you indicate fa	Date of Birth D MM YYY DELETE ife	Name of Person(s AD & D O V igible dependents. Illocation \$	Female Male Female ELETE es, Comple Date of Cov Hospital insured unc	Student - College/Universit Disabled Student - College/Universit te the following: Verage (DD/MM/YYYY): Vision	O Dental O Date of Birth MM YYYY O Critical Illness			
Do you or any of y Name of the Othe Policy Number: Name of Employe Name of Person BASIC COVERAG O Life O Lor Dependent life is a O HCSA Allocation STATUS CHANG	ge ADD ng Term Disability automatically include n \$ E Single ERAGE ADD C Single C Emplo	O CHANGE O Dependent Led if you indicate fa Family CHANGE Family CHANGE Family CHANGE Family CHANGE Family CHANGE Family CHANGE Family	Date of Birth Date of Birth D MM YYY O DELETE ife O Health milly status and el O PSA A E O DELETE e Amount \$	Name of Person(s AD & D igible dependents. Illocation \$	Female Male Female ELETE es, Complet Date of Cov Hospital insured unc	Student - College/Universit Disabled Student - College/Universit te the following: Verage (DD/MM/YYYY): Vision O EHB O Drugs der other policy DD mnity O Dental O Spouse Amount \$	Date of Birth MM YYYY			
Do you or any of y Name of the Othe Policy Number: Name of Employe Name of Person BASIC COVERAG Life	ge ADD ng Term Disability automatically include n \$ E Single ERAGE ADD C Single C Emplo	O CHANGE O Dependent Led if you indicate far Divided Employed Divided Divided Employed Divided Divi	Date of Birth D MM YYY D DELETE ife	Name of Person(s AD & D igible dependents. Illocation \$	Female Male Female ELETE es, Complet Date of Cov Hospital insured unc	Student - College/Universit Disabled Student - College/Universit te the following: Verage (DD/MM/YYYY): Der other policy DD mnity Dental	Date of Birth MM YYYY			

2 224	DI ETE ONI V ADEAG A	SEEGTED BY THE GUANGE	- AND CION (
	PLETE ONLY AREAS A	AFFECTED BY THE CHANGE	E AND SIGN (C	ont.) ——			
In accordance	ce with the terms and condi	itions of the Group Life Contract b	•	•			
		ents of beneficiary and hereby ap I share equally unless otherwise in		g as beneficiary	entitled to receive the pro	ceeds arising t	y reason
(First Name	Last Name		Percentage (Must total 100%)	Relationship	Revocab	le Irrevocable
				(Must total 100%)			
						0	0
						0	0
						0	0
	First Name	Last Name	Date of Birth	Percentage (Must total 100%)	Relationship	Telephone	Number
Contingent							
Contingent							
	ited beneficiaries considers	ered a minor: I appointericiary considered a minor under	the provincial juri	ediction of reside	ance		_ as Trustee
By choosing	•	nges to your beneficiary designation	•			eficiary(ies) whe	en the
IN QUEBEC	, THE DESIGNATION OF \	YOUR SPOUSE AS BENEFICIAR	RY IS PRESUMEI) IRREVOCABLI	E UNLESS OTHERWISE	SPECIFIED.	
For the provi	nce of Quebec - Where the	e beneficiary of a life insurance po	olicy is a minor at	the time of the in	sured's death, Medavie E	Blue Cross will	pay the
proceeds to to have anot	parent(s) (or other legal gu her person administering th	ardian, if applicable), and not to a ne child's proceeds, you should e re are some estate planning steps	nyone else who r nsure you have t	night be named a	as administrator/trustee o ons in your will. You may	f the proceeds	If you wish
MARITAL C	HANGE						
		from single to family coverage wintract. If later than 31 days, a Stat				ctive as outline	d in the
Date of cha	nge in Marital Status (DD/I	MM/YYYY):					
If Spouse h	as Medavie Blue Cross b	enefits, please complete:					
Policy Numb	oer:lde	ntification Number:		Last Name:			
AUTHORIZ	ATION OF CHANGE						
I certify that information.	the information above is a	ccurate and authorize payroll dedu	uctions, if require	d. I authorize Blu	e Cross to collect, use an	nd disclose my	personal
Cross and/o which I am a coverage I o organization	or Blue Cross Life Insurance an eligible member, to reco carry, limited personal infor us, health care professional	tion provided herein, as well as an e Company of Canada, may be co mmend suitable products and ser mation may be collected from and s or institutions, life and health ins outlined in the policy of which I ar	bllected, used, or vices to me, and /or released to a surers, governme	disclosed to adm to manage Blue third party. Thes nt and regulatory	ninister the terms of my po Cross's business. Depen to third parties include oth	olicy or the grounding on the typener Blue Cross	up policy of oe of
instances do	oing so may prevent Blue C	cion will be kept confidential and so Cross from providing me with the r ts of consenting or refusing to con	equested coverage	ge or benefits. I			
		be as valid as the original. This c Blue Cross, visit medaviebc.ca or			provincial privacy laws. F	or additional ir	nformation
Employee S	ignature:				_ Date:		
Witness Sig	nature:				_ Date:		
	E COMPLETED BY EM	IDLOVED -					

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/YYYY):
Complete for Life and Disability Income Benefits: Earnings per O Hour O Month	O Week O Year \$ Hours Worked Per Week:
Payroll Number (Maximum 9 positions): (1)	(2)
Completed for Employer by:	
Signature:	Date:

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