

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | Fax: 604 419-2149 | enrollment@pac.bluecross.ca

PART 1 — MEMBER INFORMATION

Policy number	Benefit plan to be changed <input type="checkbox"/> Dental <input type="checkbox"/> Extended Health <input type="checkbox"/> BC Life <input type="checkbox"/> Other: _____	ID number
First name	Last name	Middle initial
Name of company/organization		Effective date of employee change (mm-dd-yyyy)

PART 2 — EMPLOYEE CHANGE: Check all relevant boxes and provide requested information

<input type="checkbox"/> Name change	Employee's former name		
<input type="checkbox"/> Address change	New street address	City	Province Postal code
<input type="checkbox"/> Salary change	New salary \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually	Hours per week	
<input type="checkbox"/> Division change	New division	New sub-division	
<input type="checkbox"/> Class/Payroll change	New class	New section ID	New payroll number Occupation (required for class change)
<input type="checkbox"/> Employment type change	<input type="checkbox"/> Full-time salary <input type="checkbox"/> Part-time salary <input type="checkbox"/> Full-time hourly <input type="checkbox"/> Part-time hourly <input type="checkbox"/> Retired <input type="checkbox"/> Hour bank <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Terminate employee	Date (mm-dd-yyyy)	Reason for termination	
<input type="checkbox"/> Transfer employee	Terminate from policy number	Add to policy number	Reason for transfer

PART 3 — DEPENDENT CHANGE: Check all relevant boxes and provide requested information

Add Change Terminate Name change

If adding a spouse: Date of marriage (mm-dd-yyyy): _____ Date of cohabitation (mm-dd-yyyy): _____

If you or any of your dependents were covered under another plan within the last 6 months, please indicate the following:

Name of other insurance company	Name of member with other insurance company	Benefits covered under the other plan <input type="checkbox"/> EHC <input type="checkbox"/> Dental	
Is the plan still active? <input type="checkbox"/> Yes <input type="checkbox"/> No — termination date (mm-dd-yyyy): _____	Group/policy number(s)	Effective date (mm-dd-yyyy)	ID or certificate number

Please provide the information requested in the table below.

Does your spouse/child have a government health/medical plan in any province or territory, e.g. MSP?

FIRST NAME	LAST NAME	MIDDLE INITIAL	BIRTHDATE	SEX		SEE REQUIRED INFORMATION INSTRUCTIONS ON PAGE 2
			(mm-dd-yyyy)	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	
			(mm-dd-yyyy)	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	
			(mm-dd-yyyy)	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	
			(mm-dd-yyyy)	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	
			(mm-dd-yyyy)	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	

PART 4 — EMPLOYEE AND EMPLOYER/PLAN ADMINISTRATOR SIGNATURES

I hereby declare that all the information provided in this application is true and complete. I consent to the personal information provided above being retained, used and disclosed in accordance with Pacific Blue Cross/BC Life's privacy policy.

The privacy policy is available online at www.pac.bluecross.ca or by calling Pacific Blue Cross/BC Life at 604 419-2000.

Employee's signature X	Date (mm-dd-yyyy)
Employer/Plan administrator's signature X	Date (mm-dd-yyyy)

REQUIRED INFORMATION INSTRUCTIONS

1. If you are adding:
 - A dependent — Give relationship to employee.
If you are adding a legal ward, attach a copy of court document.
 - A child that is over the maximum age (as stated in your Group Benefit Contract) and attending school full-time — Provide school name and student number.
 - Handicapped child — Include a *Disabled Dependent Application Form*, available at www.pac.bluecross.ca. Their coverage will be continued beyond the minor maximum age if certain criteria are met.
 - Adopted child — Attach a copy of adoption papers.
2. If you are terminating dependent(s) — Give reason and termination date.
3. If you are changing dependent's name — Give former name.

! **INCOMPLETE INFORMATION MAY DELAY THE PROCESSING OF YOUR FORM.**



MAIL YOUR FORM

Pacific Blue Cross

PO Box 7000, Vancouver, BC V6B 4E1



DROP IT OFF

4250 Canada Way

Burnaby, BC V5G 4W6



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EMAIL IT

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