

644 MAIN ST PO BOX 220 MONCTON NB E1C 8L3 230 BROWNLOW AVE DARTMOUTH PO BOX 2200 HALIFAX NS B3J 3C6 FOR ALL INQUIRIES: TEL 1-800-667-4511 FAX 506-869-9653

THIS AREA MUST BE COMPLETED FOR CHANGES TO BE PROCESSED Existing Identification Number _ Existing Policy and Section Number __ Last Name

Instructions:

Emplo	oyer to forwa	ard original a	and keep sec	ond copy.		ment benefits a										
	Optional Gro increase / c		ance Statem	nent of He	alth form mus	st be completed	when an ADD or C	CHANGE is requeste	ed for Optional L	ife benefits. The ac	tual amo	ount of co	verage	must be st	tated (no	ot the amount
		,					TYPE OF CHA	NGE - CHECK (<u> </u>							
□ Addr	229	■ Marita	l Status	□ Bene	eficiary	☐ Left Emp		el Benefits: Reas	,							
	endent(s)	□ Retire			ohone No.	□ Salary	•	Benefits: Reason								
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,								FIRST NAME	INITIAL	different from applicant)*		DD MM		Stat		C-Change D-Delete
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Postal Code Language Preferred English French										JSE ARE NOT L OF CO-HABITA			IED, F	LEASE I	PROVI	DE
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Do you	or any c	of your de	pendents	have c	overage u	ınder any otl	ner Plan? 🚨	Yes □ No								
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of Cana	da, I revol	ke all previ	ous appoin	tments o	of beneficia	s and condition ry and hereby	ons of the Group appoint the folk	Life Contract be owing as benefic	tween the emplication in the emp	ployer indicated receive the proc	below a ceeds a	ind Blue rising by	cross	n of my o	urance death. S	Company Surviving
benefici		share equa Last Name	•	otherwise	e indicated.	First Name	.	Percentage	Ral	ationship			Revo	cable	Irro	vocable
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2. —															_	
3. ——								Must total 100%)								_
						oint tion of reside				as Tr	ustee to	receive	any a	mount du	ue for a	any
	•			•	•			without the written	consent of tha	t beneficiary(ies)	when th	e benefi	ciarv(ie	es) is/are	the age	of majority.
•	•	-	•	•				ED IRREVOCAB		, ,) (.,		
								at the time of the								
								inistrator/trustee want to consult v								
•		upport you	•	o uno pro	por proviois	nio in your wii	i. Tou may aloo	want to consult v	viiii a logal ool	andor to dotomin	10 111101	1101 111010	o alo c	01110 0010	ato piai	minig otopo
							•	age within 31 da		e, family coverag	e will be	ecome e	ffectiv	e as outli	ined in	the
		• .		ntract. If	later than 3	1 days, a Stat	ement of Health	form may be red	•	saa Madassia Dis	0	a hanaf	ام ما:			_
Date of	cnange ii	n marital s	status:						if spouse r	ıas Medavie Blı	ie Cros	s benet	its, pi	ease cor	npiete	:
DD	MI	M \	ſΥ					Policy	Number	Identification	Numbe	er		Last	Name	1
AUTHO	RIZATION	OF CHAI	NGE - I cer	tify that	the informa	tion above is a	accurate and au	thorize payroll de	eductions, if re	quired. I authori	ze Blue	Cross to	colle	ct, use ar	nd disc	lose my
persona	al informati	ion as desc	cribed in the	e Privac	y Statemen	t on the revers	se of this form.									
Employ	ee Signatu	ıre					 Witness Signa 	ature				_ Date _				
		_				то в	E COMPLETED	BY EMPLOYER	3							
Name o	f Employe	er				Policy a	nd Section Num	ber Class of Co and/or Den	overage - Heal tal	th Employee C or Disability		fe and/	Occu	pation		
			Dom-1-1-1	ov 1 14	nd Dissisting				tal	or Disability	Income	fe and/	Occu	pation		
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PRIVACY STATEMENT

I understand that the personal information provided herein, as well as any other personal information currently held or collected in the future by Medavie Blue Cross and/or Blue Cross Life Insurance Company of Canada, may be collected, used, or disclosed to administer the terms of my policy or the group policy of which I am an eligible member, to recommend suitable products and services to me, and to manage Blue Cross's business. Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These third parties include other Blue Cross organizations, health care professionals or institutions, life and health insurers, government and regulatory authorities, and other third parties when required to administer and manage the benefits outlined in the policy of which I am an eligible member.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time, however, in some instances doing so may prevent Blue Cross from providing me with the requested coverage or benefits. I understand why my personal information is needed and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure.

A photocopy of this authorization shall be as valid as the original. This consent complies with federal and provincial privacy laws. For additional information regarding privacy policies at Medavie Blue Cross, visit www.medavie.bluecross.ca or call 1-800-667-4511.