SASKATCHEWAN
BLUE CROSS®

516 2nd Avenue North, PO Box 4030
Saskatoon, SK S7K 3T2

CHANGE FORM
GRPA 1004

Complete relevant areas of the form and return to your Plan Administrator for completion and submission.

THIS AREA MUST BE COMPLETED FOR CHANGES TO BE PROCESSED

Existing ID Number: ____________

Existing Policy Number: ____________

Last Name: ____________

TO BE COMPLETED BY EMPLOYER - COMPLETE ONLY AREAS AFFECTED BY CHANGE

Name of Employer: ____________

Effective Date of Change: ____________

Class: ____________ Division #: ____________

Occupation: ____________

Change to Payroll I.D. Number: ____________

Complete for Life & Income Replacement Benefits:

Earnings: $ ____________

☐ Hourly ☐ Weekly
☐ Monthly ☐ Yearly

Hours Worked per Week: ____________

Completed for Employer by:

Signature ____________ Date (DD/MM/YYYY) ____________

COMPLETE ONLY AREAS AFFECTED BY CHANGE AND SIGN

Last Name ____________ First Name ____________

Address ____________

City ____________ Province ____________ Postal Code ____________

Email Address ____________

Phone Number ____________ ☐ Home ☐ Work ☐ Mobile

	Name (First, Last)	Birth Date (DD/MM/YYYY)	Sex* M/F/I/U	Dependent Status	A- Add C- Change D - Delete
Employee				E - Student (College/University) S - Disabled	
Partner					
Children					

***Sex: Male/Female/Intersex/Undisclosed** - *Why do we ask?* Some health conditions are more likely to occur based on sex. As a result, sex is used to assess your coverage. We recognize your sex may differ from your gender identity.

BASIC COVERAGE

☐ Add ☐ Change ☐ Delete

☐ Life ☐ AD&D ☐ Health
☐ Weekly Indemnity ☐ Dental ☐ Dependent Life
☐ Critical Condition ☐ Long Term Disability

WAIVER OF BENEFITS

I have been given the opportunity to apply for coverage but do not wish to participate. I understand that I will not be able to enrol in these plans at a later date without the mutual consent of my employer and Saskatchewan Blue Cross.

☐ Waive ALL Benefits ☐ Waive Only: ____________

OPTIONAL COVERAGES

☐ Add ☐ Change ☐ Delete

(Medical Underwriting is required.)

Life (state total amt in units of $10,000)
Employee $ ____________
Partner $ ____________

☐ Add ☐ Change ☐ Delete

AD&D (state total amt in units of 10,000) $ ____________

AUTHORIZATION OF CHANGE

I certify that all information contained herein is correct and hereby authorize payroll deductions, if required, for the changes specified. **I have read the Acknowledgment and Consent on Page 2 of this form.**

Signature ____________

Date (DD/MM/YYYY) ____________

PLEASE REFER TO ACKNOWLEDGMENT AND CONSENT ON PAGE 2.

STATUS CHANGE

Type of Status Change:
☐ Marriage ☐ Cohabitation

Date of Marriage/Cohabitation: ____________ DD/MM/YYYY

If partner has other coverage please complete **COORDINATION BENEFITS SECTION.**

COORDINATION OF BENEFITS

Do you or any of your dependents have alternate Health and/or Dental coverage?

☐ Yes ☐ No **If Yes, please complete the following:**

Name of Cardholder ____________ Date of Birth (DD/MM/YYYY) ____________

Name of Other Insurer ____________ Policy No. ____________ I.D. Number ____________

Coverage Effective Date (DD/MM/YYYY) ____________

Type of Coverage: ☐ Health ☐ Dental ☐ Other: ____________

Covered Insureds: ☐ All ☐ Partner ☐ Specific Insureds: ____________

BENEFICIARY DESIGNATION

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 (in equal shares, unless otherwise designated).

Beneficiary Last Name	First Name	Age	Relationship	Share
				%
				%
				%

TRUSTEE DESIGNATION (COMPLETE IF BENEFICIARY IS UNDER AGE 18):

I hereby appoint the trustee named here to receive any amount due my beneficiary under age 18 and authorize such trustee to spend all or any portion of such amount and the income from it for the maintenance and education of such minor.

Last Name ____________ First Name ____________

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sk.bluecross.ca
1.800.667.6853

ACKNOWLEDGMENT & CONSENT

I understand that the personal information I have given, as well as any other personal information currently held or provided in the future by Saskatchewan Blue Cross, Blue Cross Life Insurance Company of Canada and/or its agents may be collected, used, maintained and disclosed for the purposes of determining eligibility for coverage, underwriting, administering products and services, audit and investigation, confirming my identity, maintaining my relationship with Saskatchewan Blue Cross, and to help develop and recommend suitable products and services to me.

Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These include other Blue Cross® organizations, and/or their authorized agents/brokers, representatives, licensed physicians, practitioners or other healthcare providers, hospitals, clinics or other medical facilities, other health and life insurers and reinsurers, MIB, LLC, employers (past and present) government and regulatory authorities, and other third parties only when needed for a purpose stated above.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, coverage may be denied or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding the privacy policies of Blue Cross and/or the collection, use or disclosure of my personal information, I can visit www.sk.bluecross.ca or call 1.800.667.6853.

A photocopy of this authorization shall be as valid as the original.