MANITOBA BLUE CROSS®

NOTICE OF CHANGE FORM

CERTIFICATE NUMBER _____

MEMBER'S NAME _____

GROUP NUMBER _____ ROLL NUMBER _____ EMPLOYEE NUMBER _____

EMPLOYER NAME _____

MEMBER: Please complete the appropriate section(s) and return to your Plan Administrator.

1- CHANGE OF MAILING ADDRESS

EFFECTIVE DATE _____
DD MM YYYY

MAILING ADDRESS - STREET/BOX NUMBER _____

CITY, TOWN AND PROVINCE _____ POSTAL CODE _____

2 - TERMINATION

DATE OF TERMINATION _____
DD MM YYYY

REASON _____

3 - CHANGE OF NAME (if due to marriage, section 4 must be completed)

FROM _____
NAME IN FULL

TO _____
NAME IN FULL

4 - ADDITION OF SPOUSE AND/OR DEPENDENT

NAME IN FULL _____

RELATIONSHIP TO MEMBER: (Please check)

- ☐ LEGAL SPOUSE
- ☐ COMMON-LAW SPOUSE
- ☐ CHILD
- ☐ COMMON-LAW CHILD
- ☐ OTHER _____

GENDER ☐ Male ☐ Female DATE OF BIRTH _____
DD MM YYYY

DATE OF MARRIAGE/ COHABITATION _____
DD MM YYYY

5 - DELETION OF SPOUSE AND/OR DEPENDENT (S)

NAME IN FULL _____

REASON _____ DATE _____
DD MM YYYY

6 - CO-ORDINATION OF BENEFITS

☐ I AND / OR MY DEPENDENTS HAVE COVERAGE THROUGH ANOTHER INSURANCE PLAN

☐ I AND / OR MY DEPENDENTS LOST COVERAGE THROUGH ANOTHER INSURANCE PLAN

CANCELLATION DATE _____
DD MM YYYY

BENEFITS COVERED (PLEASE COMPLETE FOR EITHER CHECKED ABOVE)

☐ AMBULANCE ☐ DENTAL ☐ PRESCRIPTION DRUGS

☐ VISION ☐ HEALTH ☐ HSA ☐ HOSPITAL

NAME OF INSURED _____

NAME OF INSURANCE COMPANY _____

7 - OTHER CHANGES (SPECIFY)

_____

_____

_____

☐ I CERTIFY THE ABOVE INFORMATION IS TRUE AND CORRECT AND THAT ALL PARTICIPANTS ARE ELIGIBLE FOR COVERAGE AS PER THE GROUP AGREEMENT. I UNDERSTAND IT IS MY RESPONSIBILITY TO NOTIFY MANITOBA BLUE CROSS IMMEDIATELY IF A PARTICIPANT NO LONGER MEETS THE CRITERIA TO REMAIN ON MY PLAN. I HAVE READ AND UNDERSTAND THE AUTHORIZATION & CONSENT AND AGREE TO THE CONDITIONS OF THE GROUP AGREEMENT BETWEEN MY EMPLOYER AND MANITOBA BLUE CROSS.

MEMBERS SIGNATURE _____ DATE _____
DD MM YYYY

PLAN ADMINISTRATORS SIGNATURE _____ DATE _____
DD MM YYYY

AUTHORIZATION & CONSENT

I UNDERSTAND THAT THE PERSONAL INFORMATION PROVIDED HEREIN AS WELL AS ANY OTHER PERSONAL INFORMATION CURRENTLY HELD OR COLLECTED IN THE FUTURE BY MANITOBA BLUE CROSS MAY BE COLLECTED, USED, OR DISCLOSED TO ADMINISTER THE TERMS OF THE GROUP POLICY OF WHICH I AM AN ELIGIBLE MEMBER, TO DEVELOP AND RECOMMEND SUITABLE PRODUCTS AND SERVICES TO ME, AND TO MANAGE THE COMPANY'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 PLANS, HEALTH CARE PROFESSIONALS OR INSTITUTIONS, HEALTH AND LIFE INSURERS, GOVERNMENT AND REGULATORY AUTHORITIES, AND OTHER THIRD PARTIES WHEN REQUIRED TO ADMINISTER THE BENEFITS OUTLINED IN MY POLICY OR THE GROUP 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, IF CONSENT IS WITHHELD OR REVOKED, THE 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 MANITOBA BLUE CROSS'S PRIVACY POLICIES I CAN CONTACT MANITOBA BLUE CROSS AT 204.775.0151 OR 1.800.873.2583 OR WWW.MB.BLUECROSS.CA SHOULD I HAVE QUESTIONS AS TO THE COLLECTION, USE OR DISCLOSURE OF MY PERSONAL INFORMATION.

I AUTHORIZE MANITOBA BLUE CROSS TO COLLECT, USE AND DISCLOSE MY PERSONAL INFORMATION AS DESCRIBED ABOVE.