

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

PART 1 — MEMBER INFORMATION

Policy number	Member ID number		
Legal first name	Last name	Middle initial	
Name of company/organization			Effective date of member change (mm-dd-yyyy)

PART 2 — MEMBER 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 Name change Terminate (specify reason): _____

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	Group policy number	ID certificate number
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Is the plan still active? Yes No — termination date (mm-dd-yyyy): _____

LEGAL FIRST NAME	PREFERRED NAME	MIDDLE INITIAL	LAST NAME	BIRTHDATE (MM-DD-YYYY)	GENDER*	RELATIONSHIP TO YOU*	FULL TIME STUDENT**	DISABLED DEPENDENT***
Spouse					<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> U <input type="checkbox"/> X	<input type="checkbox"/> Common-Law <input type="checkbox"/> Married		
First child					<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> U <input type="checkbox"/> X	<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Stepchild	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Second child					<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> U <input type="checkbox"/> X	<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Stepchild	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Third child					<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> U <input type="checkbox"/> X	<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Stepchild	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fourth child					<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> U <input type="checkbox"/> X	<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Stepchild	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

*F = Female, M = Male, U = Prefer not to disclose, X = Another gender

**If applicable, attach a copy of adoption papers or for a legal ward, a copy of the court document.

**Complete this section if child is over the maximum age as stated in your Group Benefit Contract and attending school full-time.

***If you have a child with a disability, provide a copy of CRA approved Application for Disability Tax Credit or Persons With Disability and confirm the following:

1. Is the dependent currently active on the plan? Yes No
2. Is the dependent financially dependent on you? Yes No
3. Does the dependent reside with you? Yes No
4. Is the dependent married, or has the dependent ever been married? Yes No

(If unable to provide CRA or PWD document, attach a completed Disabled Dependent Application for review.)

PART 4 — MEMBER 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' privacy policy. The privacy policy is available online at pac.bluecross.ca or by calling Pacific Blue Cross at 604 419-2000.

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

