

A. EMPLOYEE INFORMATION	
Name:	Employee number:
Mailing address:	Employee birth date: YYYY MM DD / /
	Phone number: ()

B. ADD OR TERMINATE ADDITIONAL BENEFIT COVERAGE INFORMATION	
Name of family member with additional benefit coverage:	Family member birth date: YYYY MM DD / /
Name of other insurance company:	Policy number:
	Identification number:

Please list the benefits covered and individuals that are included under the above noted plan. To add coverage, please include the effective date of other coverage or to delete coverage, please include the termination date. Use additional forms if necessary.

Last name	First name	Relationship (spouse, partner, daughter, son)	Effective date of coverage (YYYY/MM/DD)	Termination date of coverage (YYYY/MM/DD)	Other insurance coverage		
					Drugs	EHC*	Dental
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

*EHC – Extended Health Care (e.g. massage, physiotherapy, psychiatry services, hospital, etc.)

In the case of dependents and custody situations (i.e. divorce), additional information may be required. If you have any questions, please contact Alberta Blue Cross Customer Services toll-free at 1-800-661-6995 or 498-8000 from Edmonton and surrounding area.

C. CONSENT AND AUTHORIZATION FOR USE OF PERSONAL INFORMATION
<p>In order to administer your Caritas group benefits plan, Alberta Blue Cross must collect personal information from you and/or any of your dependents when you, your spouse and/or dependents are covered under more than one insurance plan. This information is used to adjudicate your claims and to make the most of other coverage your dependents have, thereby reducing your out-of-pocket expenses.</p> <p>I consent to the collection, use and disclosure of personal information as described above.</p> <p>I have been authorized by all dependents for whom coverage is applied for through me, to consent on their behalf to the collection, use and disclosure of their personal information for the above purposes.</p> <p>I may revoke my consent at any time and acknowledge that doing so may affect my eligibility to receive group benefits. I understand why the information is required and am aware of the risks and benefits of consenting or refusing to consent to its disclosure.</p> <p>I agree to the above and declare that my statements in this notice are complete, accurate and true. I agree to notify Alberta Blue Cross of any changes to eligibility and enrolment information as described above.</p>

Signature: _____ Date signed: _____

Send completed form to: **Alberta Blue Cross**
Attention: Major Accounts
10009 108 Street, Edmonton AB T5J 3C5