

OVER-AGE DEPENDENT DECLARATION

EMPLOYEE'S NAME		DATE OF BIRTH	YYYY	MM	DD	GROUP AND SECTION NUMBER	ID NUMBER		
DEPENDENT'S SURNAME	GIVEN NAME AND INITIALS	RELATIONSHIP			DATE OF BIRTH	YYYY	MM	DD	
I declare that the above named dependent as defined in the Employee Benefits Booklet is: (Check appropriate box and enter dates as required.)						YYYY	MM	DD	
<input type="checkbox"/> An unmarried child over the dependent age but under the maximum age specified in the Employee Benefits Booklet. This dependent must be attending an accredited educational institution on a full-time basis. (NOTE: An annual <i>Over-age Dependent Declaration</i> is required for each school year.)						START OF SCHOOL TERM:	YYYY	MM	DD
Name of Educational Institution: _____						END OF SCHOOL TERM:	YYYY	MM	DD
<input type="checkbox"/> An unmarried child, over the dependent age as specified in the Employee Benefits Booklet, but fully dependent on me due to a continuous mental or physical disability.									
I certify that all the above information is true and complete and agree to the Acknowledgement and Consent on the reverse side of this form. I understand and agree that it is my responsibility to advise Alberta Blue Cross immediately should the dependent named cease to be eligible.									
EMPLOYEE'S SIGNATURE: _____						TODAY'S DATE:	YYYY	MM	DD
EMPLOYER APPROVAL: _____						DATE:	YYYY	MM	DD

*The Blue Cross symbol and name are registered marks of the Canadian Association of Blue Cross Plans, an association of independent Blue Cross plans. Licensed to ABC Benefits Corporation for use in operating the Alberta Blue Cross Plan.

ABC 30230 (R06/2010)

DISTRIBUTION: [Employer's Records](#)

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DISTRIBUTION: [Send to Alberta Blue Cross, 10009-108 Street, Edmonton AB T5J 3C5](#)

ACKNOWLEDGEMENT AND CONSENT

I understand that the personal information provided herein about me and an eligible dependent, as well as any other personal information currently held or collected in the future by Alberta Blue Cross and/or Blue Cross Life Insurance Company of Canada* (if my plan includes life and disability benefits), may be used or disclosed to determine eligibility for benefits; verify, assess and pay claims; administer the terms of my benefit plan and policy and to manage the Company's business. I certify that I am authorized by the eligible over-age dependent to disclose and receive information about him/her that is used for these purposes.

I hereby acknowledge and agree that my/my dependent's personal information may be exchanged between Alberta Blue Cross and a licensed physician and/or any other health care professional, institution or health benefits provider or insurer or government or regulatory authority only for a purpose stated above.

I understand that my and my dependent's personal information will be kept confidential and secure. I understand that I may revoke this consent at any time and acknowledge that should I do so, the coverage may be denied or rescinded. I understand why my/my dependent's personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its use as described above. I authorize Alberta Blue Cross to collect, use and disclose of my/my dependent's personal information as described above.

For additional information regarding Blue Cross privacy policies I can visit www.ab.bluecross.ca or contact Alberta Blue Cross at (780) 498-8100 ext. 8108 should I have questions as to the collection, use or disclosure of my/my dependent's personal information.

*For those plans with life and income replacement benefits, Blue Cross Life Insurance Company of Canada underwrites these benefits.

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