PACIFIC BLUE CROSS™ BC Life®

DO NOT WRITE IN THIS SPACE

EMPLOYEE CHANGE FORM

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | Fax: 604 419-2149 | enrollment@pac.bluecross.ca

PART 1 — MEMBER INFORMATION

Policy number	Benefit plan to be changed ☐ Dental ☐ Extended Health ☐ BC Life ☐ Other: ______	ID number

First name	Last name	Middle initial

Name of company/organization	Effective date of employee change (mm-dd-yyyy)

PART 2 — EMPLOYEE CHANGE: Check all relevant boxes and provide requested information

☐ Name change	Employee's former name			
☐ Address change	New street address	City	Province	Postal code
☐ Salary change	New salary $ ______ ☐ Hourly ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually	Hours per week		
☐ Division change	New division	New sub-division		
☐ Class/Payroll change	New class	New section ID	New payroll number	Occupation (required for class change)
☐ Employment type change	☐ Full-time salary ☐ Part-time salary ☐ Full-time hourly ☐ Part-time hourly ☐ Retired ☐ Hour bank ☐ Other: ______			
☐ Terminate employee	Date (mm-dd-yyyy)	Reason for termination		
☐ 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 ☐ Terminate ☐ Name change

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	Name of member with other insurance company	Benefits covered under the other plan ☐ EHC ☐ Dental

Is the plan still active? ☐ Yes ☐ No — termination date (mm-dd-yyyy): ______	Group/policy number(s)	Effective date (mm-dd-yyyy)	ID or certificate number

Please provide the information requested in the table below.

Does your spouse/child have a government health/medical plan in any province or territory?

FIRST NAME	LAST NAME	MIDDLE INITIAL	BIRTHDATE	SEX		SEE REQUIRED INFORMATION INSTRUCTIONS ON PAGE 2
			(mm-dd-yyyy)	☐ M ☐ F	☐ Yes ☐ No	
			(mm-dd-yyyy)	☐ M ☐ F	☐ Yes ☐ No	
			(mm-dd-yyyy)	☐ M ☐ F	☐ Yes ☐ No	
			(mm-dd-yyyy)	☐ M ☐ F	☐ Yes ☐ No	
			(mm-dd-yyyy)	☐ M ☐ F	☐ Yes ☐ No	

PART 4 — EMPLOYEE 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/BC Life's privacy policy.

The privacy policy is available from your employer/plan administrator, online at www.pac.bluecross.ca or by calling Pacific Blue Cross/BC Life at 604 419-2000.

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

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REQUIRED INFORMATION INSTRUCTIONS

1. If you are adding:
   - A dependent — Give relationship to employee.
     If you are adding a legal ward, attach a copy of court document.
   - A child that is over the maximum age (as stated in your Group Benefit Contract) and attending school full-time — Provide school name and student number.
   - Handicapped child — Include a *Disabled Dependent Application Form*, available at www.pac.bluecross.ca. Their coverage will be continued beyond the minor maximum age if certain criteria are met.
   - Adopted child — Attach a copy of adoption papers.
2. If you are terminating dependent(s) — Give reason and termination date.
3. If you are changing dependent's name — Give former name.

INCOMPLETE INFORMATION MAY DELAY THE PROCESSING OF YOUR FORM.

MAIL YOUR FORM
Pacific Blue Cross
PO Box 7000, Vancouver, BC V6B 4E1

DROP IT OFF
4250 Canada Way
Burnaby, BC V5G 4W6

FAX IT
604 419-2149

EMAIL IT
enrollment@pac.bluecross.ca

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