P.O. BOX 1046, WINNIPEG, MAN. R3C 2X7
TEL: (204) 775-0161 FAX: (204) 774-1761

CHANGE FORM

THIS AREA MUST BE COMPLETED FOR CHANGES TO BE PROCESSED

CONTRACT NUMBER ____________________
GROUP NUMBER ____________________
NAME ____________________

Instructions:
1) Earnings information is only required if life and/or income replacement benefits apply.
2) **Employer to forward original and keep second copy.**
3) The Optional Group Life Insurance Statement of Health form must be completed when an ADD or CHANGE is requested for Optional Life benefits. The **actual** amount of coverage must be stated (not the amount of the increase / decrease).

TYPE OF CHANGE - CHECK (✓)

❑ Address	❑ Marital Status	❑ Beneficiary	❑ Left Employ	❑ Other ________
❑ Telephone No.	❑ Salary	❑ Benefits	❑ Deceased	________
❑ Dependent(s)	❑ Occupation	❑ Retired	❑ Transfer	________

COMPLETE ONLY AREAS AFFECTED BY THE CHANGE AND SIGN

Employee's Last Name	
Address (Street & No.)	
City or Town	Province
Postal Code	Telephone No. ( )

FULL NAME	SEX M/F	BIRTH DATE Day	Mo.	Yr.	Dependent Status	A-Add C-Change D-Delete
Employee					E-Student (College/ University) S-Disabled	
Spouse						
Children						

BASIC COVERAGE

❑ ADD ❑ CHANGE ❑ DELETE

❑ Life & AD&D	❑ * Health	* May not delete
❑ Dependent Life	❑ * Dental	unless there is
❑ Weekly Indemnity	❑ * Travel	duplicate employer
❑ Long Term Disability	❑ * Employee Assistance	Group coverage
❑ Critical Conditions		

OPTIONAL COVERAGES

❑ ADD ❑ CHANGE ❑ DELETE

Life (state total amt.)	Employee $________	Spouse $________
AD&D (state total amt.)	❑ Single ❑ Family	$________
Dependent Child Life	❑ YES ❑ NO	

CHANGE OF BENEFICIARY

In accordance with the terms and conditions of the Group Life Contract between the employer indicated below and Blue Cross Life Insurance Company of Canada, I revoke all previous appointments of beneficiary and hereby appoint the following as beneficiary entitled to receive the proceeds arising by reason of my death.

	Beneficiary Last Name	First Name	Initial	Relationship	Percentage
1.					
2.					
3.					

Employee's Signature ____________________ Date ____________

MARITAL CHANGE

❑ Legal
Date of Marriage ______ Day ______ Month ______ Year

❑ Common-Law
Commencement Date of Co-Habitation ______ Day ______ Month ______ Year

If Spouse has Blue Cross Coverage Please Complete ________ Group No. ________ Contract No. ________ Last Name

Any change not received within 31 days will be subject to the current underwriting practices of Blue Cross.

AUTHORIZATION OF CHANGE

I certify that all information contained hereon is correct and hereby authorize payroll deductions, if required, for the changes specified.

____________________ Employee's Signature ____________ Date

TO BE COMPLETED BY EMPLOYER

Name of Employer	Group and Roll Number	Employee Class - Life and/or Disability Income	Occupation

Date of Change Day	Mo.	Yr.	Complete for Life and Disability Income Benefits	Hours Worked Per Week	Payroll No. (maximum 9 positions)	Completed for Employer by
			Earnings Per ❑ Hour ❑ Month ❑ Week ❑ Year $________			________ Signature ________ Date

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BLUE CROSS LIFE INSURANCE COMPANY OF CANADA UNDERWRITES ALL LIFE AND DISABILITY INCOME BENEFITS.

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