

## **GUARANTEED ACCEPTANCE PLAN**

Tell us who you are								
From your Ontario Blue Cross Card -								
Identification Number:	Policy Number:	Name:						
CHANGE YOUR PERSONAL INFOI	RMATION							
O Address - My new address is:		O <b>Telephone:</b> My new number is:						
		O Email: My new email address is:						
		○ Name						
		Previous Name:						
Postal	Polity Numbers Name:    O Telephone: My new number its   O Email: My new email address its:							
CHANGE METHOD OF PAYMENT								
	pt pre-authorized debit (PA	D)						
I/We authorize Canassurance Hospital Services Cross"), and the financial institution designated for recurring payments and/or one-time paymer confirmation of my/our PAD agreement and prebefore the first debit is processed. Regular montotification but will provide 3O days notice if the debits. Blue Cross requires written notification of This authority is to remain in effect until Blue Cr least thirty (3O) business days before the next da sample cancellation form or more information.	Association and its subsidian (or any other financial institutes, from time to time, for pays-notification of the amount of the payments will be debited e deduction is subject to char of any changes to banking inficutes as checked written notification my/our right to cancel a foces not comply with this agread Agreement. To obtain a foces not comply with this agread the control of the control o	ries <sup>1</sup> & Medavie Inc., doing business as tition I/we may authorize at any time) to ments of insurance premiums. I/we and the PAD and agree that I/we do not on the first business day of every mornge. Blue Cross will obtain my/our authormation.  Fication from me/us of its change or teation must be sent to the Administration ADD Agreement at my/our financial in ement. For example, I/we have the right material in the sent to the control of	o begin deductions as per my/our instructions n/are waiving my/our right to receive require 15 days notification of the amount of the cross will not provide monthly prehorization for any other one-time or sporadic ermination. This notification must be received at on Department of Blue Cross. I/We may obtain stitution or by visiting cdnpay.ca.					
Type of Service: O Personal O Business	Please attach a void che	que.						
Financial Institution (FI): (PLEASE PRINT)								
			Postal Code:					
FI Transit Number:								
Whoever will be paying for the premiums, please	e sign and complete your per	sonal information below:						
Name:								
Address:								
			ince:Postal Code:					
		•						
<sup>1</sup> Canassurance Hospital Service Association is carrying on business as Ontario	Blue Cross®.							
CHANGE IN DIRECT DEPOSIT INF	ORMATION							
Eligible Benefits will be reimbursed through el	lectronic funds transfer (dire							
BANK ACCOUNT INFORMATION - PLEASI	•							
Please attach a void cheque.  Financial Institution:		Telephon	e Number:					
			Postal Code:					
FI Transit Number:	FI Account No							
Date:	Signature(s) of Bank	Account holder(s):						

CHANGE IN COVERAGE										
O Type of Coverage	√ Add	✓ Delete	O Add/Remov	e a Family Member						
O Premium Drugs - \$2500			O Change in Marital Status							
O Travel			Date of marriage or cohabitation							
O Iravei				pouse or dependent						
				ate of eligibility or if			aw spous	se,		
Are all individuals to be covered under the personal health			•	a completed application must be submitted.  O Change in Dependent Status						
plan currenthly covered by a Provincial Health Plan in Ontario (OHIP)?  O Yes O No If No, please explain:		First Name	Last Name	Sex*	Date of Birth DD MM YY	Full-Time	A = Add C = Change			
		A 15	00	M/F/I/U	DD MM YY	Student	D = Delete			
		Applicant Spouse/Cohabitar	00 t** 01							
			Child	O2						
			Child Child	O3 O4						
		_	Child	05						
			your sex may differ fr	tersex/Undisclosed - Why don sex. As a result, sex is usr om your gender identity. an individual who is married or resides at the same addri						
CANCELLATION OF COVERAGE	E OR CHAN	IGE APPLICA	NT							
☐ Request for Cancellation of Coverage					Change	of Applican	t			
If cancellation, please check $\oslash$ one of the fo	llowing reasons	i:	ffective Date D/MM/YYYY)							
O Gone to Medavie Blue Cross group plan		(D	D/1*(1*() + + + +)	Effective (date),				L _		
	the Member under this identification number shall be deemed to be:									
Identification Number				-						
O Gone to another carrier (individual plan)	Name									
O Gone to another carrier (group plan)	_ Signature of									
O Moved - No longer require coverage				prior applicant						
O Deceased - Provide estate address and date of death				Signature of						
Deceased - Provide estate address and date of death				new applicant						
				''						
Other, indicate reason										
				•						
● REMARKS										
AUTHORIZATION OF CHANGE										
I certify that all information is correct and he	ereby authorize	Blue Cross to an	nend my policy accor	dinalv.						
22. 2.7 that an information is correct and he	50, 400,101126	J. 033 to un	, policy decor							
C:	ature of Man-	er or Power of At	tornov				Data			
	ature of Membe	er or Power of At	torney				Date			



