QUÉBEC BLUE CROSS
1981 MCGILL COLLEGE AVENUE, SUITE 105
MONTREAL, QUEBEC H3A OH6
TEL: 1-855-906-8993

Complete Health
Change Form

Please print in ink or type information.

TELL US WHO YOU ARE

From your Blue Cross Card -

Identification Number: _____ Policy Number: _____

Name: _____

☐ CHANGE YOUR PERSONAL INFORMATION

☐ **Address - My new address is:** (Street & No.): _____

City/Town: _____ Province: _____ Postal Code: | | | | | | |

☐ **E-mail address - My new e-mail address is:** _____

☐ **Telephone- My new Number is:** _____

☐ **Name:**

Previous Name: _____ New Name: _____

☐ CHANGE IN BILLING INFORMATION

Name of Payer: _____ Telephone Number: _____

Address: _____

City/Town: _____ Province: _____ Postal Code: _____

BANK ACCOUNT INFORMATION - PLEASE PRINT

Please attach a void cheque.

Financial Institution (FI): _____ Telephone Number: _____

Address: _____

City/Town: _____ Province: _____ Postal Code: _____

FI Transit Number: | | | | | (branch - 5 digits; | | | | FI - 3 digits) FI Account Number: | | | | | | | | | | | | |

Type of Service: ◯ Personal ◯ Business

I/We authorize Canassurance Insurance Company and its subsidiaries & Medavie Inc., doing business as Medavie Blue Cross® (collectively "Blue Cross"), and the financial institution designated (or any other financial institution I/we may authorize at any time) to begin deductions as per my/our instructions for recurring payments and/or one-time payments, from time to time, for payments of insurance premiums. Regular monthly payments will be debited on the first business day of every month. I/We waive my/our right to receive confirmation and pre-notification of the amount of the PAD. I/We have agreed that I/we do not require advance notice of the amount ten (10) days before the first PAD. In the event of a change in the amount, Blue Cross will provide thirty (30) days' notice specifying the new terms.

Blue Cross will obtain my/our authorization for any other one-time or sporadic debits. I/We certify that all information provided in relation to the account is accurate. I/We undertake to notify Blue Cross in writing of any change with respect of the account against which it has designated PADs to be drawn at least thirty (30) days before the date of the next withdrawal. In the event of such a change, this PAD Agreement will be maintained with regard to any new account information. I/We consent to the disclosure of my/our personal information contained in this PAD Agreement to the designated financial institution (or any other financial institution that I/we may authorize at any time).This authority is to remain in effect until Blue Cross has received written notification from me/us of its change or termination. This notification must be received at least thirty (30) business days before the next debit is scheduled. This notification must be sent to the Administration Department of Blue Cross. I/We may obtain a sample cancellation form or more information on my/our right to cancel a PAD Agreement at my/our financial institution or by visiting payments.ca.

I/We have certain recourse rights if any debit does not comply with this agreement. For example, I/we have the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. To obtain a form for a reimbursement claim, or for more information on my/our recourse rights, I/we may contact my/our financial institution or visit payments.ca.

Date: _____ **Signature(s) of Bank Account holder(s):** _____

☐ CHANGE IN DIRECT DEPOSIT INFORMATION

Eligible expenses will be reimbursed through electronic funds transfer (direct deposit). I choose to use the same banking information as:
◯ Billing ◯ Use the banking information below. I may cancel this authorization at any time by giving written notice to Blue Cross.

BANK ACCOUNT INFORMATION - PLEASE PRINT

Please attach a void cheque.

Financial Institution: _____ Telephone Number: _____

Address: _____

City/Town: _____ Province: _____ Postal Code: _____

FI Transit Number: | | | | | (branch - 5 digits; | | | | FI - 3 digits) FI Account Number: | | | | | | | | | | | | |

Date: _____ **Signature(s) of Bank Account holder(s):** _____

☐ CHANGE IN COVERAGE

○ Type of Coverage	✓ Add	✓ Delete
☐ Entry health benefit	○	○
☐ Essential health benefit	○	○
☐ Enhanced health benefit	○	○
☐ Essential drug* benefit	○	○
☐ Enhanced drug* benefit	○	○
☐ Entry dental benefit	○	○
☐ Essential dental benefit	○	○
☐ Enhanced dental benefit	○	○
☐ Critical Illness	○	○
☐ Hospital Cash	○	○
☐ Assured Access	○	○

A change in coverage may require an evaluation through the underwriting process.

Please select the reason(s) for the change and complete the table below:

○ **Add/Remove a Family Member**

○ **Change in Marital Status**

Date of marriage or cohabitation _____

Note: if a spouse or dependent is added more than 60 days after the date of eligibility or if adding a common-law spouse, a completed application must be submitted.

○ **Change in Dependent Status**

First Name	Last Name	Sex* M/F/I/U†	Date of Birth DD MM YY	Full-Time Student	A = Add C = Change D = Delete
Applicant	01				
Spouse**	02				
Child	03				
Child	04				
Child	05				
Child	06				

* Sex: Male/Female/Intersex/Undisclosed – *Why do we ask?* Some health conditions are more likely to occur based on sex. As a result, sex is used to assess your coverage. We recognize that your sex may differ from your gender identity. †Select the U option if you prefer not to answer.

** Spouse shall mean an individual who is married to the applicant, or in a conjugal relationship for at least one year or resides at the same address as the applicant.

If you are adding a person to be insured, are they covered by the Québec Provincial Health Plan (RAMQ)? ○ Yes ○ No If No, please explain:

_____

*To subscribe to the Drug benefit, you and all listed dependents must be covered by the Public Prescription Drug Insurance Plan administered by the RAMQ or by an equivalent group insurance plan.

☐ CANCELLATION OF COVERAGE OR CHANGE APPLICANT

☐ **Request for Cancellation of Coverage**

If Cancellation, please ✓ one of the following reasons **Date (DD/MM/YYY)**

○ Gone to Blue Cross group plan _____

Identification Number _____

○ Gone to another carrier (individual plan) _____

○ Gone to another carrier (group plan) _____

○ Moved - No longer require coverage _____

○ Deceased - Provide estate address and date of death _____

_____

○ Other, indicate reason _____

☐ **Change of Applicant**

☐ **Effective Date** _____ The Applicant under this identification number shall be deemed to be:

Name: _____

Signature of prior applicant: _____

REMARKS

AUTHORIZATION OF CHANGE

I certify that all information is correct and hereby authorize Blue Cross to amend my policy accordingly.

Signature of Applicant _____ **Date** _____