QUÉBEC BLUE CROSS
1981 MCGILL COLLEGE AVENUE, SUITE 105
MONTREAL, QUEBEC H3A 0H6
TEL: 1-855-906-8993

GUARANTEED ACCEPTANCE CHANGE FORM

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: ____________

❍ **Telephone -** My new Number is: ____________

❍ **E-mail address -** My new e-mail address is: ____________

❍ **Name -** Previous Name: ____________ New Name: ____________

❍ CHANGE METHOD OF PAYMENT

Please complete the agreement below to accept pre-authorized debit (PAD)

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.

Type of Service: ❍ Personal ❍ Business Please attach a void cheque. (Credit card payments are not accepted.)

Financial Institution (FI): (PLEASE PRINT)

Address: ____________

City/Town: ____________ Province: ____________ Postal Code: ____________

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

Whoever will be paying for the premiums, please sign and complete your personal information below:

Name: ____________

Address: ____________

City/Town: ____________ Province: ____________ Postal Code: ____________

Phone Number: (Work) ____________ (Home/Mobile) ____________

DATE: ____________ Authorized Signature(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: ☐☐☐☐☐ ☐☐☐ FI Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐
(branch - 5 digits; FI - 3 digits)

DATE: ____________ **Signature(s) of Bank Account holder(s):** ____________

❍ CHANGE IN COVERAGE

❍ Change Type of Coverage	✓ Add	✓ Delete
Travel Benefit	❍	❍
Policies with an effective date starting from June 1, 2024 Drug Benefit* (for those aged 65 over)	❍	❍
Policies with an effective date before June 1, 2024 Drug Benefit*	❍	❍

* To be eligible for the Drug Benefit, you and all listed dependents must be enrolled in the Public Prescription Drug Insurance Plan (PPDIP) administered by the RAMQ or have an equivalent group insurance.

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

❍ **Add/Remove a Family Member**
If you are adding a person to be insured, are they covered by the Quebec Provincial Health Plan (RAMQ)?
❍ Yes ❍ No If No, please explain:

❍ **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/YYYY	Full-Time Student?	A = Add C = Change D = Delete
Applicant	00				
Spouse/Cohabitant**	01				
Child	02			❍ Yes ❍ No	
Child	03			❍ Yes ❍ No	
Child	04			❍ Yes ❍ No	
Child	05			❍ Yes ❍ No	

*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 the husband or wife of the applicant. Cohabitant shall mean any one individual named in the application by the applicant in lieu of a spouse, provided he or she resides at the same address as the applicant. *Note: a child cannot be named as a cohabitant so long as he or she qualifies as a dependent child under this policy.*

❍ CANCELLATION OF COVERAGE OR CHANGE APPLICANT

❑ **Request for Cancellation of Coverage**

If cancellation, please check ✓ one of the following reasons: Effective Date (DD/MM/YYYY)

❍ 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 ____________

Signature of new 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 ____________

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