

# Assured Access Change Form for Complete Health

## APPLICANT'S PERSONAL INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Address - Street and No. \_\_\_\_\_

City/Town \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Telephone No. (Home) \_\_\_\_\_ Telephone No. (Work) \_\_\_\_\_

Telephone No. (Other) \_\_\_\_\_ E-mail Address \_\_\_\_\_

You will be contacted by e-mail. Your policy booklet will be issued by e-mail.

## FROM YOUR BLUE CROSS ID CARD

Policy Number \_\_\_\_\_ Identification Number \_\_\_\_\_

## COVERAGE CHANGE (Check appropriate box below)

Activate Personal Health Plan: First-time  
*(I have never activated a personal health plan from Assured Access)*

Activate Personal Health Plan: Follow-up  
*(I have previously activated a personal health plan from Assured Access)*

Termination date of group health benefits \_\_\_\_\_

For Blue Cross Group Plans:  
Please provide your previous

Policy Number: \_\_\_\_\_

Identification Number: \_\_\_\_\_

For non-Blue Cross Group Plans:  
Written confirmation of benefit loss is required from employer

Place personal plan on hold and activate  
**Assured Access**

Name of employer from which you receive or will receive  
group health benefits \_\_\_\_\_

Effective Date of group health benefits \_\_\_\_\_

I have group benefits, but would like to keep the  
following active:

- Critical Illness  Hospital Cash  Travel  
 Entry Dental  Essential Dental  Enhanced Dental  
 I would like to opt my kids out of the Dental plan.

Does change apply to all plan applicants?  Yes  No  
If not, list applicants affected by the change

\_\_\_\_\_  
\_\_\_\_\_

## EFFECTIVE DATE OF CHANGE

Requested effective date of change \_\_\_\_\_

Coverage must commence on the 1<sup>st</sup> day of a month. The requested date of change is subject to Blue Cross approval.

## AUTHORIZATION OF CHANGE

I certify that all of the above information is correct and hereby authorize Blue Cross to proceed with the changes as stated on this form.

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

**IMPORTANT NOTE:** Premium payments and claim deposits will continue to be processed through the banking information on record. Please notify Blue Cross on any changes to your banking information.

**Select from the following benefits to be activated**

**COMPLETE HEALTH**

**Health Benefit**

- Entry
- Essential
- Enhanced
  - Travel **(Optional for individuals 65 years and over)**

**Drug Benefit**

- Essential
- Enhanced

**Dental Benefit**

- Entry
- Essential
- Enhanced
  - I would like to opt my kids out of the Dental plan.

**Additional Benefit**

- Assured Access
- Hospital Cash **(may require medical qualification)**
- Critical Illness **(may require medical qualification)**

Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_

**REPRESENTATIVE INFORMATION (if applicable)**

I hereby certify that, as a representative for Blue Cross, I have informed the applicant of the importance of making full and accurate disclosure of the matters covered in this application and that any misrepresentations or omissions may give Blue Cross the right to cancel the contract of insurance and refuse coverage under the policy. I have disclosed the company or companies I represent and any conflicts of interest they may have with respect to this transaction and that I may receive a salary, commissions or other forms of compensation for the sale of insurance company products.

Representative's Signature \_\_\_\_\_ Representative's Number \_\_\_\_\_

Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Representative's Name (please print) \_\_\_\_\_ E-mail Address \_\_\_\_\_

Address \_\_\_\_\_

Representative's Comments

