

ASSURED ACCESS
PROTECTING TOMORROW'S INSURABILITY TODAY

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 circle 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 Medavie 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 members affected by the change:

EFFECTIVE DATE OF CHANGE

Requested effective date of change: _____

Coverage must commence on the 1st 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 Ontario 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 Ontario Blue Cross on any changes to your banking information.



AUTHORIZATION OF CHANGE

Select from the following benefits to be activated

COMPLETE HEALTH

Health Benefit

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

Dental Benefit

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

Drug Benefit

- Essential
- Enhanced

Additional Benefits

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

AGENT INFORMATION (IF APPLICABLE)

I hereby certify that, as an agent for Ontario 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 Ontario 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.

 Agent's Signature Agent's Number Telephone Number Fax Number

 Agent's Name (please print) Email Address

 Address

 Agent's Comments