

○ CHANGE IN COVERAGE

○ Change Type of Coverage	✓ Add	✓ Delete
Travel Benefit	<input type="radio"/>	<input type="radio"/>
Policies with an effective date starting from June 1, 2024		
Drug Benefit (for those aged 65 over)	<input type="radio"/>	<input type="radio"/>
Policies with an effective date between November 1, 2023 and May 31, 2024		
Drug Benefit	<input type="radio"/>	<input type="radio"/>
Policies with an effective date before November 1, 2023		
Standard Drug Plan (\$1,000/CY)	<input type="radio"/>	<input type="radio"/>
Premium Drug Plan (\$2,500/CY)	<input type="radio"/>	<input type="radio"/>

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 Ontario Provincial Health Plan (OHIP)?

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			<input type="radio"/> Yes <input type="radio"/> No	
Child	03			<input type="radio"/> Yes <input type="radio"/> No	
Child	04			<input type="radio"/> Yes <input type="radio"/> No	
Child	05			<input type="radio"/> Yes <input type="radio"/> 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 ✓ one of the following reasons

Effective Date (DD/MM/YYYY)

- Gone to Medavie 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 _____