

○ CHANGE IN COVERAGE

○ Type of Coverage	✓ Add	✓ Delete
<input type="radio"/> Entry health benefits		
<input type="radio"/> Essential health benefits		
<input type="radio"/> Enhanced health benefits		
<input type="radio"/> Essential drug benefits		
<input type="radio"/> Enhanced drug benefits		
<input type="radio"/> Entry dental benefits		
<input type="radio"/> Essential dental benefits		
<input type="radio"/> Enhanced dental benefits		
<input type="radio"/> Critical Illness		
<input type="radio"/> Hospital Cash		
<input type="radio"/> 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	O1				
Spouse/Cohabitant**	O2				
Child	O3				
Child	O4				
Child	O5				
Child	O6				

* 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.

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:

○ CANCELLATION OF COVERAGE OR CHANGE APPLICANT

Request for Cancellation of Coverage

If Cancellation, please ✓ one of the following reasons

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 Member 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** _____