Group Health & Dental Change Form

Insurer: Medavie Blue Cross

EMPLOYEE NAME: **EMPLOYEE ID#:**

DATE OF COVERAGE: M / D /Y :

SECTION 1: TYPE OF CHANGE ☒ **MC/Operational Support ☐** **Faculty/Professional Support ☐**

☐ **Add Dental** **Single ☐** **Family ☐**
☐ **Add Health** **Single ☐** **Family ☐**
☐ **Add/Delete Dependent(s)**
Reason: _____

Change Current Status to: Single ☐ Family ☐

☐ **Cancel Dental (proof of comparable coverage required)**
Reason: _____
☐ **Cancel Health (proof of comparable coverage required)**
Reason: _____

The following life events could result in the change of benefits coverage:

- The birth of a child/adoption
- Adding a step-child who resides with the employee
- Marriage
- Common-law Status (co-habitation period of 12 months reached)
- Termination of Coverage through alternate plan

Requests submitted for the change in benefits as a result of any of the above events made within 31 days of the event will provide for guaranteed coverage effective on the date of change. Changes made 31 days after these events will result in a **Late Enrollment** process whereby a **Medavie Blue Cross *Statement of Health Form** must be completed and placed in an envelope marked Strictly Confidential and forwarded to the Group Benefits Consultant, Human Resources, Central Office, NSCC. The Group Benefits Consultant will submit the Statement of Health to Medavie Blue Cross for adjudication. Medavie Blue Cross will communicate their decision via a letter to the applicant once determined.

SECTION 2: COMPLETE ONLY AREAS AFFECTED BY THE CHANGE AND SIGN BELOW

Plan Member	Last Name	First Name Initial	Gender M/F	Birth Date MM	Birth Date DD	Birth Date YY	Dependent Status	A – Add C – Change D - Delete
Employee							E – Student (College/ University) S - Disabled	
Spouse								
Child								
Child								
Child								

****IF APPLICANT AND SPOUSE ARE NOT LEGALLY MARRIED, PLEASE PROVIDE DATE OF COMMENCEMENT OF CO-HABITATION**
Date:

SECTION 3: COORDINATION OF BENEFITS

Do you or any of your dependents have other coverage under the same insurer or any other Insurer? ☐ Yes ☐ No
if Yes, complete the following

Name of other Insurer: _____ Effective date of Coverage: _____

Identification Number/Certification Number: _____ Policy Number: _____

Is the Coordination of Benefits Single Coverage or Family Coverage? Please indicate under the "Type of Coverage" below -
S for Single or F for Family for the applicable benefits.

Type of Coverage: All ____ Hospital ____Extended Health Benefits ____Vision ____Drugs ____Dental ____

SECTION 4: MARITAL STATUS CHANGE – When an employee requests a change from single to family coverage within 31 days of marriage, family coverage will become effective as outlined in the Medavie Blue Cross group benefits contract. If later than 31 days, a *Statement of Health may be required. **Date of change in marital status:** _____.

SECTION 5: DECLARATION AND AUTHORIZATION OF CHANGE – I certify that all information contained herein is correct and hereby authorize payroll deductions, if required. I authorize Blue Cross to collect, use and disclose my personal information. If applying for benefits for my spouse and/or dependents, I certify that I am authorized to release information concerning my spouse and/or dependents, for the purposes of administering and managing the benefit plan.

_____ _____

Signature of Employee **Date** **Employee Services Advisor** **Date**

Return completed form to your Employee Services Advisor

PRIVACY STATEMENT

I understand that the personal information provided herein, as well as any other personal information currently held or collected in the future by Medavie Blue Cross and/or Blue Cross Life Insurance Company of Canada, may be collected, used, or disclosed to administer the terms of my policy or the group policy of which I am an eligible member, to recommend suitable products and services to me*, and to manage Blue Cross's business. Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These third parties include other Blue Cross organizations, health care professionals or institutions, life and health insurers, government and regulatory authorities, and other third parties when required to administer and manage the benefits outlined in the policy of which I am an eligible member.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time, however, in some instances doing so may prevent Blue Cross from providing me with the requested coverage or benefits. I understand why my personal information is needed and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure.

A photocopy of this authorization shall be as valid as the original. This consent complies with federal and provincial privacy laws. For additional information regarding privacy policies at Medavie Blue Cross, visit www.medavie.bluecross.ca or call 1-800-667-4511. *not applicable in Ontario or Quebec