

NOTICE OF CHANGE FORM

CERTIFICATE NUMBER							
MEMBER'S NAME							
GROUP NUMBER	ROLL NUM	MBER		EMPLOYEE NUM	BER		
EMPLOYER NAME							
MEMBER: Please complete th	e appropriate sect	ion(s) and retur	n to your Pl	an Administrator.			
1- CHANGE OF MAILING	ADDRESS						
EFFECTIVE DATE	YYYY						
MAILING ADDRESS - STREET/E							
CITY, TOWN AND PROVINCE							
DATE OF TERMINATION	MM YYYY						
3 - CHANGE OF NAME (if		section 4 must l	pe complete	ed)			
FROM							
		NAME IN FU	L				
10		NAME IN FU	L				
4 - ADDITION OF SPOUS	E AND/OR DEP	PENDENT					
NAME IN FULL							
RELATIONSHIP TO MEMBER: (F	^o lease check)						
LEGAL SPOUSE							
COMMON-LAW SPOUSE							
CHILD COMMON-LAW CHILD							
GENDER 🔲 Male 🔲 Female				DATE OF MARRIAGE/			
		DD MM	YYYY	COHABITATION	DD	MM	YYYY
5 - DELETION OF SPOUS	E AND/OR DEF	PENDENT (S)					
NAME IN FULL							
				DATE _			
					DD	MM	YYYY

6 - CO-ORDINATION OF BENEFITS
I AND / OR MY DEPENDENTS HAVE COVERAGE THROUGH ANOTHER INSURANCE PLAN
I AND / OR MY DEPENDENTS LOST COVERAGE THROUGH ANOTHER INSURANCE PLAN
CANCELLATION DATE
DD MM YYYY
BENEFITS COVERED (PLEASE COMPLETE FOR EITHER CHECKED ABOVE)
AMBULANCE DENTAL PRESCRIPTION DRUGS
VISION HEALTH HSA HOSPITAL
NAME OF INSURED
NAME OF INSURANCE COMPANY
7 - OTHER CHANGES (SPECIFY)

I CERTIFY THE ABOVE INFORMATION IS TRUE AND CORRECT AND THAT ALL PARTICIPANTS ARE ELIGIBLE FOR COVERAGE AS PER THE GROUP AGREEMENT. I UNDERSTAND IT IS MY RESPONSIBILITY TO NOTIFY MANITOBA BLUE CROSS IMMEDIATELY IF A PARTICIPANT NO LONGER MEETS THE CRITERIA TO REMAIN ON MY PLAN. I HAVE READ AND UNDERSTAND THE AUTHORIZATION & CONSENT AND AGREE TO THE CONDITIONS OF THE GROUP AGREEMENT BETWEEN MY EMPLOYER AND MANITOBA BLUE CROSS.

MEMBERS SIGNATURE	DATE		
	DD	MM	YYYY
PLAN ADMINISTRATORS SIGNATURE	DATE	DATE	

AUTHORIZATION & CONSENT

I understand that the personal information provided herein as well as any other personal information currently held or collected in the future by Manitoba Blue Cross may be collected, used, or disclosed to administer the terms of the group policy of which I am an eligible member, to develop and recommend suitable products and services to me, and to manage the company'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 Plans, health care professionals or institutions, health and life insurers, government and regulatory authorities, and other third parties when required to administer the benefits outlined in my policy or the group policy of which I am an eligible member. I understand that Manitoba Blue Cross may retain service providers inside and outside of Canada to assist them in their business and further understand that my personal information may be subject to disclosure to law enforcement and other authorities, where required by law, both inside and outside of Canada, when such information is in the possession of Manitoba Blue Cross or one of its authorized service providers.

I understand that I have provided my consent for Manitoba Blue Cross to collect, use and disclose my personal information as outlined in the Manitoba Blue Cross Privacy Code. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, the coverage may be denied or rescinded.

I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding Manitoba Blue Cross's privacy policies or for questions as to the collection, use or disclosure of my personal information, I can contact Manitoba Blue Cross at 204.775.0151 or 1.800.873.2583 or mb.bluecross.ca.

I authorize Manitoba Blue Cross to collect, use and disclose my personal information as described above.

