MEDAVIE BLUE CROSS™

PO BOX 220 MONCTON NB E1C 8L3
TEL: 1-800-667-4511 FAX: 506-867-4651

PERSONAL HEALTH CHANGE FORM

Tell us who you are

From your Medavie Blue Cross Card -

Identification Number: _____ Policy Number: _____ Name: _____

Change your Personal Information

☐ **Address** - My new address is:

_____

_____

_____ Postal Code: _____

☐ **Telephone:** My new number is: ___-___-___

☐ **Name**

Previous Name: _____

New Name: _____

Change Method of Payment

☐ **Quarterly** ☐ **Monthly Pre-Authorized Debit (PAD)**

If you have chosen the PAD option, please complete the agreement below:

I/we authorize Medavie Blue Cross and the financial institution designated (or any other financial institution I/we may authorize at any time) to begin deductions as per my/our instructions for recurring payments and/or one-time payments, from time to time, for payment of insurance premiums. Regular monthly payments will be debited to my/our specified account on the first business day of every month. Medavie Blue Cross will not provide pre-notification but will provide 30 days notice if the deduction is subject to change. Medavie Blue Cross will obtain my/our authorization for any other one-time or sporadic debits. Medavie Blue Cross requires written notification of any changes to banking information.

This authority is to remain in effect until Medavie Blue Cross has received written notification from me/us of its change or termination. This notification must be received at least thirty (30) business days before the next debit is scheduled. This notification must be sent to the Administration Department of Medavie Blue Cross. I/We may obtain a sample cancellation form or more information on my/our right to cancel a PAD Agreement at my/our financial institution or by visiting www.cdnpay.ca.

I/we have certain recourse rights if any debit does not comply with this agreement. For example, I/we have the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. To obtain a form for a Reimbursement Claim, or for more information on my/our recourse rights, I/we may contact my/our financial institution or visit www.cdnpay.ca.

Type of Service: ☐ Personal ☐ Business **Please attach a void cheque. (Credit card payments are not accepted.)**

Financial Institution (FI): **(PLEASE PRINT)** _____

Address: _____

City/Town: _____ Province: _____ Postal Code: _____

FI Transit Number: |_|_|_|_|_| (branch - 5 digits; |_|_|_| FI - 3 digits) FI Account Number: |_|_|_|_|_|_|_|_|_|_|_|_|

Whoever will be paying for the premiums, please sign and complete your personal information below:

Name: _____

Address: _____

City/Town: _____ Province: _____ Postal Code: _____

Phone Number: (Bus.) ___-___-___ (Res.) ___-___-___

DATE: _____ Authorized Signature(s): _____

Change Coverage

☐ **Type of Coverage**	✔ Add	✔ Delete
☐ Base - (Hosp./Travel/EHB)		
☐ Travel*		
☐ Drugs no deductible*		
☐ Drugs with deductible*		
☐ Dental		
☐ Critical Conditions*		
☐ Medi-cash/Hospital Cash*		
☐ Assured Access Module		
☐ Other _____		

* If adding these benefits please complete an individual health application.

Add/Remove a Family Member

☐ **Change in Marital Status**

Date of marriage or cohabitation _____

Note: if a spouse or dependent is added more than 30 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	Initial	Sex M/F	Birth Date DD	MM	YY	Dependent Status	**A**-Add **C**-Change **D**-Delete
						Spouse	
						E-Student (College/ University) **S**-Disabled	

Are all individuals to be covered under the personal health plan currently covered by a Provincial Health Plan within Canada (i.e. Medicare in New Brunswick, Medical Services Insurance in Nova Scotia, Prince Edward Island Hospital and Medical Services Plan or Newfoundland and Labrador Medical Care Plan)? ☐ Yes ☐ No If No, please explain:

_____

Cancellation of Coverage or Change Applicant

☐ **Request for Cancellation of Coverage**

If cancellation, please check ☑ 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 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 Medavie Blue Cross to amend my policy accordingly.

Signature of Member or Power of Attorney	Witness	Date	Clerk's Initials