MANITOBA BLUE CROSS®

PO BOX 1046 STN MAIN WINNIPEG MB R3C 2X7
TEL: 204.775.0151 FAX: 204.772.1231

MUNICIPAL EMPLOYEE BENEFITS PROGRAM

PO Box 764 – Winnipeg MB R3C 2L4

GROUP INSURANCE PLAN CHANGE FORM

Instructions:

1) **Employer to forward original and keep second copy.**

TYPE OF CHANGE - CHECK (☑)

☐ Dependent(s) ☐ Maritial Status ☐ Beneficiary ☐ Other _____

Employee's Name	Address - City/Town
Gender M/F	Postal Code
Date of Birth	Phone Number

CHANGE OF BENEFICIARY FOR LIFE INSURANCE

Basic Life Coverage

Change to one of the following

☐ Option 1 – 2X Annual Earnings
Minimum $16,000
Maximum $700,000

☐ Option 2 – 1X Annual Earnings
Minimum $8,000
Maximum $700,000

Optional Life Coverage - Employee Only

Only those employees who elected Basic Life Option 1 may apply:

☐ ADD ☐ CHANGE ☐ DELETE

☐ Option 1
2X Annual Earnings
Maximum $300,000

☐ Option 1
1X Annual Earnings
Maximum $300,000

Family Coverage

(The Employee is the beneficiary of the insured spouse and children)

If you have chosen to ADD family coverage then please complete section on the right:

☐ ADD ☐ DELETE

FULL NAME	Gender M/F	Birth Date DD	MM	YYYY	Dependent Status E - Student (College/University) S - Disabled	A-Add C-Change D-Delete
Spouse						
Children						

CHANGE OF BENEFICIARY FOR LIFE INSURANCE

In accordance with the terms and conditions of the Group Life Contract between the employer indicated below and Blue Cross Life Insurance Company of Canada, I revoke all previous appointments of beneficiary and hereby appoint the following as beneficiary entitled to receive the proceeds arising by the reason of my death.

	PRIMARY BENEFICIARY LAST NAME	FIRST NAME	INITIAL	RELATIONSHIP	PERCENTAGE
1.					
2.					
3.					

Contigent Beneficiary - Applicable is the primary beneficiary (es) predeceases employee.

BENEFICIARY LAST NAME	FIRST NAME	INITIAL	RELATIONSHIP	PERCENTAGE

Designate a trustee for minor beneficiary _____

Employee's Signature _____ Date _____

MARITAL CHANGE

☐ Legal
Date of Marriage _____ dd/mm/yyyy

☐ Common-Law
Commencement Date of Co-Habitation _____ dd/mm/yyyy

☐ Separation/Divorce
_____ dd/mm/yyyy

Any change not received within 31 days will be subject to the current underwriting practices of Blue Cross.

AUTHORIZATION OF CHANGE

☐ I certify the above information is true and correct and that all participants are eligible for coverage per the group agreement. I understand that 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 understood the Authorization & Consent on the reverse side of this form and agree to the conditions of the group agreement between my employer and Manitoba Blue Cross. I hereby confirm the beneficiary designation and authorize payroll deductions if required.

Employee's Signature _____ Date _____

TO BE COMPLETED BY EMPLOYER

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Name of Employer	Employer Number	Group and Roll Number	Employee Class - Life	Coverage Amount
		41380		$ _____

Date of Change DD	MM	YYYY	Completed for Employer by
			Signature _____ Date _____

Blue Cross Life Insurance Company of Canada underwrites all life and disability income benefits.

AUTHORIZATION AND CONSENT

I understand that the personal information and personal health information provided herein as well as any other personal information and personal health information currently held or collected in the future by Manitoba Blue Cross and/or Blue Cross Life Insurance Company of Canada (collectively referred to as "Blue Cross") may be collected, used, or disclosed to administer the terms of the 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 or personal health information may be collected from and/or released to a third party. These include other Blue Cross organizations, licensed physicians and/or any other healthcare professionals or institutions, health and life insurers, government and regulatory authorities, and other third parties when required to administer the benefits outlined in the policy of which I am an eligible member.

I understand that my personal information and personal health information will be kept confidential and secure. 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 and personal health information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding Blue Cross' privacy policies as to the collection, use, or disclosure of my information, I may contact Manitoba Blue Cross at 204.775.0151 or at www.mb.bluecross.ca.

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