644 MAIN ST PO BOX 220 MONCTON NB E1C 8L3
230 BROWNLOW AVE DARTMOUTH PO BOX 2200 HALIFAX NS B3J 3C6
FOR ALL INQUIRIES: 1-800-667-4511

Personal Health Change Form

Please print in ink or type information.

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:** (Street & No.): ______________________

City/Town: ______________ Province: ______________ Postal Code: ☐☐☐ ☐☐☐

○ **E-mail addres - My new e-mail adddress is:** ______________________

○ **Telephone- My new Number is:** ______________________

○ **Name:**

Previous Name: ______________ New Name: ______________

CHANGE IN BILLING INFORMATION

Name of Payer: ______________________ Telephone Number: ______________

Address: ______________________________

City/Town: ______________ Province: ______________ Postal Code: ______________

BANK ACCOUNT INFORMATION - PLEASE PRINT
Please attach a void cheque.

Financial Institution (FI): ______________________ Telephone Number: ______________

Address: ______________________________

City/Town: ______________ Province: ______________Postal Code: ______________

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

Type of Service: ○ Personal ○ Business

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 monthly 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.

Date: ______________________

Signature(s) of Bank Account holder(s): ______________________

CHANGE IN DIRECT DEPOSIT INFORMATION

Eligible Benefits will be reimbursed through electronic funds transfer (direct deposit). I choose to use the same banking information as:
○ Billing ○ Use the banking information below. I may cancel this authorization at any time by giving written notice to Medavie Blue Cross.

BANK ACCOUNT INFORMATION - PLEASE PRINT
Please attach a void cheque.

Financial Institution: ______________________ Telephone Number: ______________

Address: ______________________________

City/Town: ______________ Province: ______________Postal Code: ______________

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

Date: ______________ **Signature(s) of Bank Account holder(s):** ______________

CHANGE IN COVERAGE

Type of Coverage	✓ Add	✓ Delete
Entry health benefits 60%		
Essential health benefits 70%		
Enhanced health benefits 80%		
Essential drug benefits 70%		
Enhanced drug benefits 80%		
Entry dental benefits 60%		
Essential dental benefits 70%		
Enhanced dental benefits 80%		
Critical Illness		
Hospital Cash		
Assured Access		
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	Last Name	Sex M/F	Date of Birth DD MM YY	Full-Time Student	A = Add C = Change D = Delete
Applicant	00				
Spouse/Cohabitant**	01				
Child	02				
Child	03				
Child	04				
Child	05				

** 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.

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 ✓ one of the following reasons — **Effective Date (DD/MM/YYY)**

◯ 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 ______ **Date** ______

Witness ______ **Clerk's Initials** ______

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