QUÉBEC BLUE CROSS
1981 MCGILL COLLEGE AVENUE, SUITE 105
MONTREAL, QUEBEC H3A OH6
TEL: 1-855-906-8993

GUARANTEED ACCEPTANCE CHANGE FORM

Tell us who you are

From your Blue Cross Card -

Identification Number: _____ Policy Number: _____ Name: _____

☐ CHANGE YOUR PERSONAL INFORMATION

☐ **Address** - My new address is:

Postal Code: _____

☐ **Telephone:** My new number is: _____

☐ **Email:** My new email address is: _____

☐ **Name**

Previous Name: _____

New Name: _____

☐ CHANGE METHOD OF PAYMENT

Please complete the agreement below to accept pre-authorized debit (PAD)

I/We authorize Canassurance Hospital Services Association and its subsidiaries[1] & Medavie Inc., doing business as Blue Cross® (collectively "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 payments of insurance premiums.

I/we am/are waiving my/our right to receive confirmation of my/our PAD agreement and pre-notification of the amount of the PAD and agree that I/we do not require 15 days notification of the amount before the first debit is processed. Regular monthly payments will be debited on the first business day of every month. Blue Cross will not provide monthly pre-notification but will provide 30 days notice if the deduction is subject to change. Blue Cross will obtain my/our authorization for any other one-time or sporadic debits. Blue Cross requires written notification of any changes to banking information.

This authority is to remain in effect until Blue Cross has received written notification from me/us of its change or termination. This notification must be received at least 30 business days before the next debit is scheduled. This notification must be sent to the Administration Department of 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 payments.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 payments.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): _____

[1] *Canassurance Hospital Service Association is carrying on business in Quebec as Québec Blue Cross®.* ® *Québec Blue Cross is a registered trademark of the Canadian Association of Blue Cross Plans.*
®† *Blue Shield is a registered trademark of the Blue Cross Blue Shield Association.*

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

DATE: _____ **Signature(s) of Bank Account holder(s):** _____

CHANGE IN COVERAGE

Type of Coverage	✓ Add	✓ Delete
Premium Drugs - $2500	○	○
Travel	○	○

Are you and all listed dependents currently covered by a Provincial Health Plan in Quebec (RAMQ)?

○ Yes ○ No If No, please explain:

☐ **Add/Remove a Family Member**

☐ **Change in Marital Status**

Date of marriage or cohabitation _____

Note: if a spouse or dependent is added more than 60 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/I/U	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				

*Sex: Male/Female/Intersex/Undisclosed – Why do we ask? Some health conditions are more likely to occur based on sex. As a result, sex is used to assess your coverage. We recognize that your sex may differ from your gender identity.

**Spouse shall mean an individual who is married to the applicant, or in a conjugal relationship for at least one year or resides at the same address as the applicant.

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 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 Applicant under this identification number shall be deemed to be:

Name _____

Signature of prior applicant _____

Signature of new applicant _____

REMARKS

AUTHORIZATION OF CHANGE

I certify that all information is correct and hereby authorize Blue Cross to amend my policy accordingly.

_____ _____

Signature of Applicant Date