ASSURED ACCESS
PROTECTING TOMORROW'S INSURABILITY TODAY

Assured Access Change Form for Complete Health

APPLICANT'S PERSONAL INFORMATION

Last Name _____ First Name _____

Address - Street and No. _____

City/Town _____ Province _____ Postal Code _____

Telephone No. (Home) _____ Telephone No. (Work) _____

Telephone No. (Other) _____ E-mail Address _____

You will be contacted by e-mail. Your policy booklet will be issued by e-mail.

FROM YOUR BLUE CROSS ID CARD

Policy Number _____ Identification Number _____

COVERAGE CHANGE (Check appropriate circle below)

☐ Activate Personal Health Plan: First-time
(I have never activated a personal health plan from Assured Access)

☐ Activate Personal Health Plan: Follow-up
(I have previously activated a personal health plan from Assured Access)

Termination date of group health benefits _____

For Blue Cross Group Plans:
Please provide your previous

Policy Number: _____

Identification Number: _____

For non-Blue Cross Group Plans:
Written confirmation of benefit loss is required from employer

☐ Place personal plan on hold and activate
Assured Access

Name of employer from which you receive or will receive group health benefits _____

Effective Date of group health benefits _____

I have group benefits, but would like to keep the following active:

☐ Critical Illness ☐ Hospital Cash ☐ Travel
☐ Entry Dental ☐ Essential Dental ☐ Enhanced Dental
☐ I would like to opt my kids out of the Dental plan.

Does change apply to all plan applicants? ◯ Yes ◯ No
If not, list applicants affected by the change

_____

_____

EFFECTIVE DATE OF CHANGE

Requested effective date of change _____

Coverage must commence on the 1st day of a month. Your previous plan coverage will be put on hold on the effective date of change. The requested date of change is subject to Blue Cross approval.

AUTHORIZATION OF CHANGE

I certify that all of the above information is correct and hereby authorize Blue Cross to proceed with the changes as stated on this form.

Signature of Applicant _____ Date _____

IMPORTANT NOTE: Premium payments and claim deposits will continue to be processed through the banking information on record. Please notify Blue Cross on any changes to your banking information.

QUÉBEC BLUE CROSS®

ASSURED ACCESS CHANGE FORM

This section to be filled in by a Blue Cross employee or approved advisor.

Select from the following benefits to be activated

BLUE CROSS COMPLETE HEALTH

Health Benefits

- ☐ Entry
- ☐ Essential
- ☐ Enhanced
  - ☐ Travel **(Optional for individuals 65 years and over)**

Dental Benefits

- ☐ Entry
- ☐ Essential
- ☐ Enhanced
  - ☐ I would like to opt my kids out of the Dental plan.

Prescription Drug Benefits

- ☐ Essential
- ☐ Enhanced

Additional Benefits

- ☐ Assured Access
- ☐ Hospital Cash **(may require medical qualification)**
- ☐ Critical Illness **(may require medical qualification)**

Authorized Signature _____ Date _____

REPRESENTATIVE INFORMATION (if applicable)

I hereby certify that, as a representative for Blue Cross, I have informed the applicant of the importance of making full and accurate disclosure of the matters covered in this application and that any misrepresentations or omissions may give Blue Cross the right to cancel the contract of insurance and refuse coverage under the policy. I have disclosed the company or companies I represent and any conflicts of interest they may have with respect to this transaction and that I may receive a salary, commissions or other forms of compensation for the sale of insurance company products.

Representative's Signature

Representative's Number

Representative's Tel. Number

Representative's Fax Number

Representative's Name (please print)

Representative's E-mail Address

Representative's Mailing Address

Representative's Comments