PACIFIC BLUE CROSS® BC Life®

DO NOT WRITE IN THIS SPACE

EMPLOYEE CHANGE FORM

PART 1 — MEMBER INFORMATION

Policy number	Benefit plan to be changed ☐ Dental ☐ Extended Health ☐ BC Life ☐ Other: _____	ID number
First name	Last name	Middle initial
Name of company/organization		Effective date of employee change (mm-dd-yyyy)

PART 2 — EMPLOYEE CHANGE: Check all relevant boxes and provide requested information

☐ Name change	Employee's former name				
☐ Address change	New street address	City		Province	Postal code
☐ Salary change	New salary $ _____ ☐ Hourly ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually			Hours per week	
☐ Division change	New division	New sub-division			
☐ Class/Payroll change	New class	New section ID	New payroll number	Occupation (required for class change)	
☐ Employment type change	☐ Full-time salary ☐ Part-time salary ☐ Full-time hourly ☐ Part-time hourly ☐ Retired ☐ Hour bank ☐ Other: _____				
☐ Terminate employee	Date (mm-dd-yyyy)	Reason for termination			
☐ Transfer employee	Terminate from policy number	Add to policy number	Reason for transfer		

PART 3 — DEPENDENT CHANGE: Check all relevant boxes and provide requested information

☐ Add ☐ Change ☐ Terminate ☐ Name change

If adding a spouse: ☐ Date of marriage (mm-dd-yyyy): _____ ☐ Date of cohabitation (mm-dd-yyyy): _____

If you or any of your dependents were covered under another plan within the last 6 months, please indicate the following:

Name of other insurance company	Name of member with other insurance company	Benefits covered under the other plan ☐ EHC ☐ Dental

Is the plan still active? ☐ Yes ☐ No — termination date (mm-dd-yyyy): _____	Group/policy number(s)	Effective date (mm-dd-yyyy)	ID or certificate number

Please provide the information requested in the table below.

Does your spouse/child have a government health/medical plan in any province or territory, e.g. MSP?

FIRST NAME	LAST NAME	MIDDLE INITIAL	BIRTHDATE	SEX		SEE REQUIRED INFORMATION INSTRUCTIONS ON PAGE 2
			(mm-dd-yyyy)	☐ M ☐ F	☐ Yes ☐ No	
			(mm-dd-yyyy)	☐ M ☐ F	☐ Yes ☐ No	
			(mm-dd-yyyy)	☐ M ☐ F	☐ Yes ☐ No	
			(mm-dd-yyyy)	☐ M ☐ F	☐ Yes ☐ No	
			(mm-dd-yyyy)	☐ M ☐ F	☐ Yes ☐ No	

PART 4 — EMPLOYEE AND EMPLOYER/PLAN ADMINISTRATOR SIGNATURES

I hereby declare that all the information provided in this application is true and complete. I consent to the personal information provided above being retained, used and disclosed in accordance with Pacific Blue Cross/BC Life's privacy policy.

The privacy policy is available online at www.pac.bluecross.ca or by calling Pacific Blue Cross/BC Life at 604 419-2000.

Employee's signature X	Date (mm-dd-yyyy)
Employer/Plan administrator's signature X	Date (mm-dd-yyyy)