EMPLOYEE CHANGE

PACIFIC BLUE CROSS™ BC Life®

for PBC office use only

Mailing Address:
PO Box 7000, Vancouver, BC V6B 4E1
Street Address:
4250 Canada Way, Burnaby, BC
Fax: 604 419-2990

Group Number(s) of Plans to be Changed

Dental Care	Extended Health	BC Life

Surname	First Name	Middle Initial	ID Number (e.g. S.I.N.)

Name of Company/Organization	Effective Date of Employee Change (mm/dd/yy)

Employee Change: Check all relevant boxes and provide requested information

❑ **Name Change** Employee's former name _____

❑ **Address Change** New address _____ City _____ Province _____ Postal Code _____

❑ **Salary Change** New salary _____ ❑ Hour ❑ Week ❑ Bi- Weekly ❑ Month ❑ Year Number of hours worked per week ____

❑ **Class/Payroll Change** New class _____ New department number _____ New employee number _____

Occupation (required for class change) _____

❑ **Terminate Employee** Date(mm/dd/yy) _____ Reason for termination _____

❑ **Transfer Employee** Terminate from group number _____ Add to group number _____ Reason for transfer _____

Dependent Change: Check all relevant boxes and provide requested information

❑ **Add** ❑ **Change** ❑ **Terminate** **the Dependent(s) listed below:**

If adding a spouse: ❑ Date of Marriage _____ (mm/dd/yy) ❑ Date of Cohabitation _____ (mm/dd/yy)

If spouse was previously covered within past 6 months, indicate the following:

Insurance Company _____ Benefits ❑ EHC ❑ Dental

Group/Policy Number(s) _____ Termination Date (mm/dd/yy) _____

Dep. No	Surname* (* not required if same as yours)	First Name	Middle Initial	Birth Date (mm/dd/yy)	Sex	Termination Date	**See instructions below for required information
					❑ M ❑ F		
					❑ M ❑ F		
					❑ M ❑ F		
					❑ M ❑ F		

**IN SPACE PROVIDED ABOVE:

1) If you are adding:
- a dependent - give relationship to employee (If you are adding a legal ward, attach copy of court document.)
- student over plan age limit (19 or 21), give name of school
- handicapped child - give nature of disability
- adopted child - give date of adoption

2) If you are terminating dependent(s) - give reason.

3) If you are changing dependent's name - give former name

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.
Note: A copy of the Privacy Policy is contained in your benefits booklet. It is also available on our Web site at www.pac.bluecross.ca or from your employer.

X _____ Signature of employee Date(mm/dd/yy)

X _____ Signature of employer Date(mm/dd/yy)

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