

Instructions: To make changes to your coverage, complete, sign and date this form.
Single Coverage is mandatory unless employee provides proof of comparable coverage.

Send completed form to Benefits@novascotia.ca or Benefits Unit PO Box 943 Halifax NS B3J 2V9 or Fax 902 424 0756. Signature is required.

Section 1: Employee Information

Last Name	First Name	Employee ID	Date of Birth (DD/MM/YYYY)
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Section 2: Active Employee Health Plan

Change coverage to:	Single <input type="checkbox"/>	Family <input type="checkbox"/>
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Eligible Dependents

Spouse Last Name	Spouse First Name	Gender	Date of Birth (DD/MM/YYYY)	Date of Cohabitation if Common Law	'A' – Add 'R' – Remove 'C' – Change
Child Last Name	Child First Name	Gender	Date of Birth	Status*	

(*): Dependent Status:
 Student - If dependent child is over age 21 and attending an accredited school, college, or university, an Overage Dependent Form is required
 Disabled - If the dependent child is physically or mentally disabled (Medavie Blue Cross approval required)
 Grandchild - Required approval by the plan administrator - Proof of financial dependence is required for coverage of a grandchild

Section 3: Life Insurance

- I wish to CANCEL my Optional Employee Life Insurance
- I wish to CANCEL my Optional Spousal Life Insurance
- I wish to CANCEL my Optional Child Life Insurance

Any changes to the amount of life insurance (reduce or increase) please complete the Optional Group Life Insurance Application Form

Section 4: Declaration and Authorization

I understand that the personal information I have provided herein is collected and used by Medavie Blue Cross to administer the terms of my policy or the group policy of which I am an eligible member, recommend suitable products and services that I am eligible for as a member of a policy, and other applicable purposes, as described in the Medavie Blue Cross Privacy Statement at <http://medaviebc.ca>. I understand that my personal information will be kept confidential and secure. Depending on the type of coverage I carry, limited personal information such as claim, health and/or financial related data may be collected from and/or released to the following third parties as required for the purposes of administering and managing the benefits outlined in the policy of which I am an eligible member. These third parties may include healthcare providers, other insurance companies, regulatory authorities and investigative bodies, services providers, and/or the cardholder of any contract under which I am a participant. Where allowed by law, my information may be shared with Medavie Blue Cross employees or service providers in jurisdictions other than where it was collected. If I am a resident of Quebec, this includes transferring or disclosing my personal information to Medavie Blue Cross employees or service providers outside of that province. I understand that my consent is only valid for the time it is needed to achieve the purposes outlined herein, unless I withdraw it. I understand I may withdraw my consent at any time. However, in some instances doing so may prevent Medavie Blue Cross from providing me with certain products or services that may be useful to me and/or my dependents. This consent complies with federal and provincial privacy laws. For more details about our information practices, including how your personal information is protected, how to access or correct personal information, or if you have concerns or questions, please see our Medavie Blue Cross Privacy Statement available at <http://medaviebc.ca> or call 1-800-667-4511.

Member's Signature:	Date:
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