ONTARIO BLUE CROSS®

185 The West Mall, Suite 610
Etobicoke, Ontario M9C 5P1
Inquiries: 1-844-745-6780

Complete Health

Personal Health Plan Change Form

Please print in ink or type information.

TELL US WHO YOU ARE

From your Blue Cross Card -

Identification Number: _____ Policy Number: _____

Name: _____

☐ CHANGE YOUR PERSONAL INFORMATION

☐ **Address - My new address is:** (Street & No.): _____

City/Town: _____ Province: _____ Postal Code: ☐☐☐ ☐☐☐

☐ **E-mail address - My new e-mail address is:** _____

☐ **Telephone- My new Number is:** _____

☐ **Name:**

Previous Name: _____ New Name: _____

☐ CHANGE IN BILLING INFORMATION

Name of Payer: _____ Telephone Number: _____

Address: _____

City/Town: _____ Province: _____ Postal Code: _____

BANK ACCOUNT INFORMATION - PLEASE PRINT
Please attach a void cheque.

Financial Institution (FI): _____ Telephone Number: _____

Address: _____

City/Town: _____ Province: _____ Postal Code: _____

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

Type of Service: ☐ Personal ☐ Business

I/We authorize Canassurance Hospital Services Association and its subsidiaries[1] & Medavie Inc., doing business as Medavie 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 thirty (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 cdnpay.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 www.cdnpay.ca.

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

[1] Canassurance Hospital Service Association is carrying on business as Ontario Blue Cross®.

☐ 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
☐ Entry health benefits 60%		
☐ Essential health benefits 70%		
☐ Enhanced health benefits 80%		
☐ Essential drug benefits 70%		
☐ Enhanced drug benefits 80%		
☐ Entry dental benefits 60%		
☐ Essential dental benefits 70%		
☐ Enhanced dental benefits 80%		
☐ Critical Illness		
☐ Hospital Cash		
☐ Assured Access		
☐ Other		

* adding benefits may require underwriting.

☐ **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	01				
Spouse/Cohabitant**	02				
Child	03				
Child	04				
Child	05				
Child	06				

** 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

*** 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.

Are all individuals to be covered under the personal health plan currently covered by a Provincial Health Plan in Ontario (OHIP)?

☐ Yes ☐ No If No, please explain:

_____

☐ CANCELLATION OF COVERAGE OR CHANGE APPLICANT

☐ **Request for Cancellation of Coverage**

If Cancellation, please ✓ one of the following reasons **Effective Date (DD/MM/YYY)**

☐ Gone to Medavie 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 Member under this identification number shall be deemed to be:

Name: _____

Signature of prior applicant: _____

REMARKS

AUTHORIZATION OF CHANGE

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

Signature of Member or Power of Attorney _____ **Date** _____