Claims processed by
PACIFIC BLUE CROSS®

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Employee Change

Healthcare Benefit Trust
Joint Community Benefits Trust
Joint Facilities Benefits Trust
Joint Health Science Benefits Trust

Mailing Address:
PO Box 7000, Vancouver, BC V6B 4E1
Street Address:
4250 Canada Way, Burnaby, BC
Fax: 604 419-2149

Division #	Sub-Div #	Class code	Policy 50000 ❑ Dental Care ❑ Extended Health Care	STD 50001

Number(s) of plans to be changed

First name	Last name	Middle initial	Benefits ID #

Name of company/organization	Effective date of employee change (mm/dd/yyyy)

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 (STD)*** New salary ____________ ❑ Hour ❑ Week ❑ Bi-Weekly ❑ Month ❑ Year Number of hours worked per week ________

❑ **Payroll No. Change** New Div/Sub-Div # ____________ New class code ____________

❑ **Terminate Employee** Date(mm/dd/yyyy)____________ Reason for termination ____________

❑ **Transfer Employee** From Div/Sub-Div #__________ To Div/Sub-Div #__________ Class code____________ Reason for transfer____________

*For STD benefit only. Do not report monthly contributory earnings in this section.

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/yyyy) ❑ Date of cohabitation ____________ (mm/dd/yyyy)

If any of your dependents were covered under another plan within the past 6 months, or are presently covered, indicate the following:
Insurance company____________Name of cardholder of other plan____________
Benefits ❑ EHC ❑ Dental Effective date (mm/dd/yyyy)____________
Group/Policy number____________ ID number____________ Termination date (mm/dd/yyyy) ____________

First name Last name Middle initial	Birth date (mm/dd/yyyy)	Sex	Termination Date (mm/dd/yyyy)	**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), attach application for over-age dependent
- disabled child, give nature of disability and attach Add a Disabled Dependent Application
- adopted child, attach copy of adoption papers

2) If you are terminating dependent(s), give reason

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

❑ I, the applicant, 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' privacy policy.

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

Signature of applicant	Date (mm/dd/yyyy)

❑ I, the employer, 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' privacy policy.

Signature of employer	Date (mm/dd/yyyy)

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