for PBC office use only

EMPLOYEE CHANGE

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

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 any of your dependents were covered under another plan within the past 6 months, indicate the following:

Insurance company ____________________ Benefits ❑ EHC ❑ Dental

Group/Policy number(s) ____________ ID number ____________ 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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® BC Life is the registered trade-name of British Columbia Life & Casualty Company, a wholly–owned subsidiary of Pacific Blue Cross.

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