OVER-AGE DEPENDENT DECLARATION

Employee: Please complete and sign this form. Keep a copy for your records, and forward the original to your plan administrator.

EMPLOYEE'S NAME	DATE OF BIRTH (YYYY / MM / DD)	GROUP AND SECTION NUMBER	ID NUMBER

DEPENDENT'S LAST NAME	FIRST NAME AND INITIALS	RELATIONSHIP	DATE OF BIRTH (YYYY / MM / DD)

I declare that the above named dependent as defined in the Employee Benefits Booklet is:
(Check appropriate box and enter dates as required.)

☐ An unmarried child over the dependent age but under the maximum age specified in the Employee Benefits Booklet. This dependent must be attending an accredited educational institution on a full-time basis.
(NOTE: An annual *Over-age Dependent Declaration* is required for each school year.)

START OF SCHOOL TERM: YYYY MM DD

Name of Educational Institution:

END OF SCHOOL TERM: YYYY MM DD

☐ An unmarried child, over the dependent age as specified in the Employee Benefits Booklet, but fully dependent on me due to a continuous mental or physical disability.

ACKNOWLEDGEMENT AND CONSENT

I understand that the personal information provided herein about me and an eligible dependent, as well as other personal information currently held or collected in the future by Alberta Blue Cross and/or Blue Cross Life Insurance Company of Canada* (if my plan includes life and disability benefits), may be used or disclosed only to determine eligibility for benefits; assess and pay claims; to verify/audit paid claims; administer the terms of my benefit plan and policy and to manage the Company's business. I certify that I am authorized by the eligible over-age dependent to disclose and receive information about him/her that is used solely for these purposes.

I hereby acknowledge and agree that my/my dependent's personal information may only be exchanged between Alberta Blue Cross and a licensed physician and/or any other health care professional, institution or health benefits provider or insurer or government or regulatory authority and only for a purpose stated above.

I understand that my and my dependent's personal information will be kept confidential and secure. I understand that I may revoke this consent at any time and acknowledge that should I do so, the coverage may be denied or rescinded. I understand why my/my dependent's personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its use as described above.

I certify that all the above information is true and complete.

I have read and understood this acknowledgement and consent. I authorize Alberta Blue Cross to collect, use and disclose of my/my dependent's personal information as described above. I understand and agree that it is my responsibility to advise Alberta Blue Cross immediately should the dependent named cease to be eligible. This consent shall be effective from the date of signature of this form and shall remain in effect as long as the coverage is in force.

EMPLOYEE'S SIGNATURE: DATE: YYYY MM DD

Plan administrator: Please sign and date and send the completed form to Alberta Blue Cross.

EMPLOYER SIGNATURE: DATE: YYYY MM DD

For additional information regarding Blue Cross privacy policies and the collection, use or disclosure of your/your dependent's personal information, visit www.ab.bluecross.ca or contact Alberta Blue Cross at 1-855-498-7302.

*For those plans with life and disability benefits, Blue Cross Life Insurance Company of Canada underwrites these benefits.

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