RETIREE BENEFIT PLANS
CHANGE FORM

Please complete pages 1 and 2

CHANGE FORM

Policy Number	Identification Number	Retiree's Last Name, First Name

Retiree's Social Insurance Number (Optional)	Vestcor Reference Number

TYPE OF CHANGE – CHECK ✔

☐ Name ☐ Telephone / Email ☐ Marital Status Change ☐ Register Student

☐ Address ☐ Coverage (cancel, change) ☐ Terminate All Coverage ☐ Register Over-Age Dependant

COMPLETE IF CHANGING PARTICIPANT INFORMATION

Last Name		First Name Initial	M/F	Date of Birth DD	MM	YY	A- Add D- Delete
Address (Street & No.)		Retiree					
City or Town	Province	Spouse					
Postal Code	Telephone Number	Children (complete page 2, if applicable)					
Email Address		Children (complete page 2, if applicable)					

COMPLETE IF CHANGING MARITAL STATUS

☐ Adding a Spouse* (proof required) ☐ Removing a Spouse Change in Marital Status: _____ DD/MM/YY

*If adding a new spouse/eligible dependant(s), the retired employee must change from single to family coverage within 31 days following the date of marriage or one year of co-habitation.

NOTE: Surviving spouses of a PNB Retiree may not add new spouses or dependants that have been acquired through re-marriage.

COMPLETE IF CANCELLING OR CHANGING COVERAGE

Benefit	Cancel	Change to:	
Health	☐	☐ Single	☐ Family
Travel*	☐	☐ Single	☐ Family
Dental	☐	☐ Single	☐ Family

*Travel is only available with health coverage. If selecting Travel, ensure you choose the same category (Single or Family) that you selected for your Health coverage.

Effective Date of Change: _____ DD/MM/YY

NOTE: Cancellation in coverage will be effective at the end of the month, not retroactive. Changes in coverage will be effective on the first of the month following the date of change request.

If cancelling coverage, I understand that :

- **After the effective date of cancellation indicated above, I will not be eligible to re-instate my coverage at any future date under the Province of New Brunswick Retiree Plan; and**
- **It is my responsibility to ensure any alternate coverage meets my needs prior to cancelling my coverage (e.g. "Will my prescription drugs be covered?").**

MANDATORY

Review and Sign Page 2

RETIREE BENEFIT PLANS
CHANGE FORM

COMPLETE IF REGISTERING/TERMINATING DEPENDANT STUDENT(S) ATTENDING POST SECONDARY EDUCATION

This is to certify that the dependant listed below is:
a) unmarried; b) unemployed; c) 21 years of age, but less than 26 years of age; AND d) attending an accredited educational institution, college or university on a full-time basis, OR e) no longer attending an accredited educational institution, college or university on a full-time basis.

Name of Dependant Student _____

Address of Depandent Student _____
Street & Number City/Town Province/State Postal/Zip Code

Check one of the following:

☐ The Dependant Student is attending _____ beginning _____.
Name of accredited school, college or university DD/MM/YY

☐ The above named dependant is no longer attending an accredited educational institution, college or university on a full-time basis and is to be removed from my benefit plan.

Note: Dependant coverage is automatically cancelled when the dependant attains age 21 or 26, unless registered as a Student Attending Post-Secondary Education.

COMPLETE IF REGISTERING AN OVER-AGE DISABLED DEPENDANT

This is to certify that the dependant listed below is:
a) your natural, adopted or step child; b) unmarried; c) unemployed; d) wholly dependant on you for financial care and support; AND e) age 21 or older with a physical or mental disability that commenced prior to age 21 and continues thereafter.

Name of Over-age Dependant _____

Address of Over-age Dependant _____
Street & Number City/Town Province/State Postal/Zip Code

* Proof of disability may be required.
Note: Dependant coverage is automatically cancelled when the dependant attains age 21 or 26, unless registered as an overage disabled dependant.

PRIVACY CONSENT AND AUTHORIZATION (REQUIRED FOR ALL CHANGES)

PRIVACY CONSENT: I understand that the personal information provided herein, as well as any other personal information currently held or collected in the future by Medavie Blue Cross and/or Blue Cross Life Insurance Company of Canada, may be collected, used, or disclosed to administer the terms of my policy or the group policy of which I am an eligible member, to recommend suitable products and services to me, and to manage Blue Cross's business. Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These third parties include other Blue Cross organizations, health care professionals or institutions, life and health insurers, government and regulatory authorities, and other third parties when required to administer and manage the benefits outlined in the policy of which I am an eligible member. In addition, I understand that the personal information provided herein will be provided to Vestcor if you choose to have monthly premiums deducted from your pension benefit.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time, however, in some instances doing so may prevent Blue Cross from providing me with the requested coverage or benefits. I understand why my personal information is needed and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure.

A photocopy of this authorization shall be as valid as the original. This consent complies with federal and provincial privacy laws. For additional information regarding privacy policies at Medavie Blue Cross, visit www.medavie.bluecross.ca or call 1-800-667-4511. Additional information regarding privacy policies at Vestcor may be submitted to Vestcor's Member Services team, by mail at P.O. Box 6000, Fredericton, NB, E3B 5H1, by phone at (506) 453-2296 or 1-800-561-4012, or by email at info@vestcor.org. In addition, Vestcor's Privacy Statement is available at vestcor.org/privacy.

AUTHORIZATION: I certify that the information above is accurate and authorize premium deductions, if required. I authorize Blue Cross to collect, use and disclose my personal information as described in the Privacy Consent section above.

Retiree Signature :_____ Date:_____

SEND COMPLETED FORM TO:

If your monthly premiums are deducted from your pension benefit, send this completed form to:

Vestcor
P.O. Box 6000
Fredericton, NB, E3B 5H1
Inquiries: 1-800-561-4012
Fax: 506-457-7388

If your monthly premiums are paid through pre-authorized debit / chequing, send this completed form to:

Medavie Blue Cross
644 Main Street, P.O. Box 220
Moncton, NB E1C 8L3
Inquiries: 1-800-667-4511
Fax : 506-869-9653

To receive your benefit newsletters electronically, sign up for paperless general communications at Vestcor.org/newsletter.

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