ALBERTA BLUE CROSS®

AMA HEALTH BENEFITS TRUST FUND

CORE PLAN APPLICATION

Please mail to: 12230 - 106 Ave NW
Edmonton, AB T5N 3Z1
Fax: 780-488-7558 or 1-877-302-3486

THIS SECTION TO BE COMPLETED BY PARTICIPANT

LAST NAME	GIVEN NAME AND MIDDLE INITIALS	PARTICIPANT DATE OF BIRTH: (YYYY-MM-DD)	
STREET ADDRESS	CITY / TOWN	PROVINCE	POSTAL CODE
TELEPHONE Home Work		GENDER ◯ Male ◯ Female ◯ Other ◯ Undisclosed	

PLEASE COMPLETE THIS SECTION FOR FAMILY COVERAGE

LAST NAME (If different than participant's) ◯ Spouse ◯ Common law	GIVEN NAME AND MIDDLE INITIALS	GENDER (X=Other, U=Undisclosed) ◯M ◯F ◯X ◯U	DATE OF BIRTH (YYYY-MM-DD)	Common Law Cohabitation Date (YY-MM-DD)

UNMARRIED DEPENDENT CHILDREN: (NOTE: If additional space is required please use the back of this page.)

LAST NAME (If different than participant's)	GIVEN NAME AND MIDDLE INITIALS	RELATIONSHIP	GENDER (X=Other, U=Undisclosed)	DATE OF BIRTH (YYYY-MM-DD)	*CODE (See below)
			◯M ◯F ◯X ◯U		
			◯M ◯F ◯X ◯U		
			◯M ◯F ◯X ◯U		
			◯M ◯F ◯X ◯U		
			◯M ◯F ◯X ◯U		

***CODES:**
A = An unmarried, fully dependent child less than the dependent age as specified in the General Provisions.
B = An unmarried child over the dependent age but under the maximum age specified in the General Provisions. This dependent must be attending an accredited educational institution on a full-time basis. **NOTE**: Please enter the date school commences beside all code B dependents. An annual *Dependency Declaration* is required for each school year.
C = An unmarried child, over the dependent age as specified in the General Provisions, but fully dependent on me due to mental or physical infirmity.

HEALTH /DENTAL COVERAGES APPLIED FOR

Benefit Status: ☐ Single ☐ Couple ☐ Family

Do you have coverage for any of the benefits applied for through another Blue Cross plan or an insurance company? ◯ No ◯ Yes - **If yes, please indicate:**

Benefits Covered	In whose name is the coverage?	Name of Employer (if Blue Cross plan) or Insuring Company	Policy Number
☐ Health ☐ Dental ☐ Drugs			

ACKNOWLEDGEMENT AND CONSENT

I certify that the information contained on this form is true and complete. I understand that the personal information provided herein as well as any other personal information currently held or collected in the future by Alberta Blue Cross may be collected, used, or disclosed to administer the terms of my benefit plan. Limited personal information may be collected from and/or released to a third party for the purpose of assessing a claim. This may include a licensed physician and/or any other healthcare professional, institution or other Blue Cross organization, health insurer or government or regulatory authority. I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, the coverage may be denied or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding Blue Cross privacy policies I can contact Alberta Blue Cross at (780) 498-8100 ext. 8108 should I have questions as to the collection, use or disclosure of my personal information. I authorize Alberta Blue Cross to collect, use and disclose my personal information as described above.

I certify that all the above information is true and complete and agree to the Acknowledgement and Consent on the reverse side of this form.

Participant Signature: _____

Date (YYYY-MM-DD): _____

FOR PARTICIPATING EMPLOYEES OF PHYSICIAN ONLY

Effective date of coverage: _____

Date of hire: _____ **Hours worked/week:** _____

Name of sponsoring physician (print): _____

Date (YYYY-MM-DD): _____

THIS SECTION IS TO BE COMPLETED BY AMA HEALTH BENEFITS TRUST FUND ADMINISTRATOR

NAME OF PLAN SPONSOR	GROUP NUMBER	AMA MEMBER NUMBER	EFFECTIVE DATE OF COVERAGE: (YYYY-MM-DD)
AMA HEALTH BENEFITS TRUST FUND	**21032**		

I hereby certify this member meets the contractual requirements of being an Eligible Member.	COMPLETED FOR PLAN SPONSOR BY	DATE (YYYY-MM-DD)	TELEPHONE	EFFECTIVE DATE OF MEMBERSHIP: (YYYY-MM-DD)

BLUE CROSS USE ONLY	GROUP, SECTION AND COVERAGE NUMBER	BENEFIT STATUS / DATE PROCESSED	STATUS	EFFECTIVE DATE (YYYY-MM-DD)