



FORM TO BE USED BY BROKERS TO ACCOMPANY PAYMENT IN THE ABSENCE OF THE ORIGINAL RENEWAL NOTICE						
Policy Number	Policyholder Name	9	Broker Name		Broker Number	
Date Due (YYYY-MM-DD)		Date Paid (YYYY-MM-DD)		Amount Paid (\$)		
Cash 🗌 Cheque 🗋 Visa 🗋 Mastercard 📄 American Express						
Credit Card Information Expiry (MMYY)						
Signature of Cardholder						
PERSONAL HEALTH PLAN RENEWAL						
Additional non-under	written options:					
Dent						
	ravel					
				TOTAL (\$)		
Additional underwritten options: A Personal Health Plan application is required for the following options: • Prescription Drugs • Hospital Cash See Personal Health Plan brochure for more information.						
Note: For monthly payment of premiums, complete and submit the Pre-authorized Payment Form for Personal Health Plans.						
CHANGE IN CONTACT INFORMATION						
From	Phone Number					
То						
CHANGE IN NAME						
From			То			
Reason						

To add a spouse or dependent, complete and submit the Personal Health Plan application at **sk.bluecross.ca/forms** or call 1.800.667.6853.

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