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EMPLOYEE CHANGE FORM

Please print clearly and complete both pages of form. Please complete SECTIONS A & F for all changes.

SECTION A: Employer / Plan Sponsor Section

Company Name: _____ Policy No: _____

Last Name: _____ First Name: _____

Certificate No: _____ Effective Date of Change: _____

Type of Change: (check all that apply)

New Employee – please complete an Employee Application

- Employee Name Change (complete Section B)
- Employee Address Change (complete Section C)
- Coverage Status Change/Termination (addition/termination of dependent coverage) (complete Section D)
- Refusal of benefits (complete Section E)

SECTION B: Employee Name Change

New Name: _____

SECTION C: Employee Address Change

Address: _____

City: _____ Province: _____ Postal Code: _____

SECTION D: Change in Coverage Status (adding/deleting dependent)

COVERAGE STATUS CHANGE FOR: Health Dental
 (check all that apply)

Current Coverage: Single Family Waived

Changing Coverage to: Single Family Waived Terminated

ADDITION OF BENEFITS Please complete dependent information:

	Last Name	First Name	Sex	Date of Birth dd/mm/yyyy
Spouse			<input type="checkbox"/> M <input type="checkbox"/> F	
Child 1			<input type="checkbox"/> M <input type="checkbox"/> F	
Child 2			<input type="checkbox"/> M <input type="checkbox"/> F	
Child 3			<input type="checkbox"/> M <input type="checkbox"/> F	
Child 4			<input type="checkbox"/> M <input type="checkbox"/> F	

