



Employee Change Form

Providing Your Innovative Benefits Solutions

Send to:

Email: claims@healthrisk.ca

Fax: (403) 236-9420

Mail: 50, 12221 - 44th Street SE

Calgary, AB T2Z 4H3

Employee: Complete section 1. Complete changes in sections 2 - 8 where applicable. Sign section 9.

1. EMPLOYEE INFORMATION

Company Name:		Group Number:
Last Name:	First Name:	ID Number:

2. CARD REPLACEMENT / REORDER

Card Type:	<input type="checkbox"/> Drug/Dental Card	<input type="checkbox"/> Travel Insurance	Date card was lost or stolen: (mm/dd/yyyy)
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3. CONTACT INFORMATION CHANGE

Street Address:		Unit #:	PO Box:
City:	Province:		Postal Code:
Telephone:		Email:	

4. NAME CHANGE (copy of name change /marriage/birth certificate required)

Relationship	Change	Last Name	First Name
<input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child	Previous Name		
	New Name		

5. DEPENDENTS CHANGE

Change	Relationship	Last Name	First Name	Date of Birth (mm/dd/yyyy)	Gender M / F	*Student Age 21-26	**Disabled Y / N
<input type="radio"/> Add <input type="radio"/> Remove	Spouse				<input type="radio"/> M <input type="radio"/> F	N/A	N/A
<input type="radio"/> Add <input type="radio"/> Remove	Child				<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> Add <input type="radio"/> Remove	Child				<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> Add <input type="radio"/> Remove	Child				<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

Effective Date: (mm/dd/yyyy) _____

Reason: ☐ Marriage ☐ Divorce ☐ Cohabitation ☐ Birth of Child ☐ Other (please specify) _____

Date of Marriage/
Cohabitation: (mm/dd/yyyy) _____

*Student: A dependent child age 21 through 26, attending an Institute of Higher Learning on a full time basis, must provide proof of paid full-time student status for claims to be processed. Complete and return the Over-Age Dependent Eligibility Declaration Form to Health Risk which must be submitted each year/term.

**Disabled Dependent: A certificate confirming the dependent's disability must be provided to Health Risk Services Inc.



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(Employee Name: _____)

6. COORDINATION OF SPOUSAL BENEFITS

Add:

☐ Health Single
☐ Dental Single

☐ Health Family
☐ Dental Family

Remove:

☐ Health Single
☐ Dental Single

☐ Health Family
☐ Dental Family

Spouse's Name:

Name of Spouse's Insurer:

Policy #:

Coordination of Spousal Benefits: If an employee's spouse has their own plan, the benefits payable under this plan will be coordinated so that the total amount received from both plans will not exceed 100% of the actual expense incurred.

Note: Canadian Life and Health Insurance Association (CLHIA) guidelines state:

(1) A spouse must first claim from his/her own employer's plan.

(2) Covered children must first claim from the plan covering the parent with the earlier date of birth in the year.

7. OPTING-IN TO COVERAGE (You may apply to enroll in coverage if you have lost coverage through your spouse's group plan)

Effective date of loss of spousal coverage: (mm/dd/yyyy)

Benefits no longer covered under the spousal plan:

☐ Extended Health Care

☐ Dental

Opting-in to Coverage: If an employee and/or their dependents lose spousal coverage, they may opt-in to coverage. Enrollment must be received by Health Risk Services within 31 days following the loss of spousal coverage or the employee and/or their dependents will be considered late applicants. Proof of loss of spousal coverage must be submitted to Health Risk Services.

8. OPTING-OUT OF COVERAGE (If allowed under the plan you may elect to opt-out of Extended Health Care or Dental because of spousal coverage)

Indicate benefits you elect not to participate in:

☐ Extended Health Care

☐ Dental

Spouse's Name:

Name of Spouse's Insurer:

Policy #:

Opting-Out of Benefits: Employees may only opt-out of Extended Health Care coverage if they are covered as a dependent through their spouse's group insurance plan.

9. SIGNATURE

I certify that all information I have given is true, correct and complete to the best of my knowledge.

Plan Member Signature:

Date Signed: