Health Risk Services Inc.

Providing Your Innovative Benefits Solutions

Employee Change Form

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: ☐ Drug/Dental Card ☐ Travel Insurance	**Date card was lost or stolen: (mm/dd/yyyy)**

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
○ Self ○ Spouse ○ 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
○ Add ○ Remove	Spouse				○ M ○ F	N/A	N/A
○ Add ○ Remove	Child				○ M ○ F	○ Yes ○ No	○ Yes ○ No
○ Add ○ Remove	Child				○ M ○ F	○ Yes ○ No	○ Yes ○ No
○ Add ○ Remove	Child				○ M ○ F	○ Yes ○ No	○ Yes ○ 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 ☐ Health Family ☐ Dental Single ☐ Dental Family	Remove:	☐ Health Single ☐ Health Family ☐ Dental Single ☐ 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: