Health Risk Services Inc.

# EMPLOYEE CHANGE FORM

Instructions: Complete Section 1 and each section that applies. Sign Section 12. Use the employee name and ID on every page. Attach the supporting documents described on page 4. Check all dates and signatures before returning the form, and keep a copy for your records.

## 1. EMPLOYEE INFORMATION

| Company / Employer | Group number |
|---|---|
| **Employee last name, first name** | **Employee ID** |
| **Effective date of change (YYYY-MM-DD)** | |

## 2. CHANGE REQUESTS

- ☐ Contact information
- ☐ Name change
- ☐ Add dependant
- ☐ Remove dependant
- ☐ Marital status change
- ☐ Beneficiary add/change
- ☐ Banking / PAD change
- ☐ Replace benefit card
- ☐ Spousal coordination
- ☐ Opt in to coverage
- ☐ Opt out of coverage
- ☐ Other: _____

## 3. CONTACT INFORMATION

| Street address | Unit / Apt. | PO Box |
|---|---|---|
| **City** | **Province** | **Postal code** |
| **Telephone** | **Email address** | |

## 4. NAME CHANGE

| Relationship | Previous last / first name | New last / first name |
|---|---|---|
| ☐ Employee ☐ Spouse ☐ Child | | |

## 5. BENEFIT CARD REPLACEMENT / REORDER

| Card type | Date lost / stolen (if applicable) |
|---|---|
| ☐ Drug / Dental ☐ Travel insurance | |

## 6. MARITAL STATUS CHANGE

**New marital status (select one)**

- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Common-law

| Spouse / partner full name | Date of marriage / common-law start |
|---|---|
| | |

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## 7. DEPENDANT ADDITION / REMOVAL

Complete one line for each dependant. For removals, identify the dependant being removed. Attach supporting documents where required by your plan. *Student: age 21-26.

| Action | Relationship | Last name | First name | Date of birth | Gender | Student* | Disabled |
|---|---|---|---|---|---|---|---|
| ☐ Add ☐ Remove | | | | | ☐ M ☐ F | ☐ Y ☐ N | ☐ Y ☐ N |
| ☐ Add ☐ Remove | | | | | ☐ M ☐ F | ☐ Y ☐ N | ☐ Y ☐ N |
| ☐ Add ☐ Remove | | | | | ☐ M ☐ F | ☐ Y ☐ N | ☐ Y ☐ N |

**Reason for change**

☐ Marriage ☐ Divorce / separation ☐ Common-law / cohabitation ☐ Birth / adoption ☐ Other (please specify): _____

## 8. BENEFICIARY ADDITION / CHANGE

Complete according to your plan requirements. Use a separate signed beneficiary designation form if required. Shares must total 100% within each category.

| Type | Full legal name | Relationship | Date of birth | Share % |
|---|---|---|---|---|
| ☐ Primary ☐ Contingent | | | | |
| ☐ Primary ☐ Contingent | | | | |
| ☐ Primary ☐ Contingent | | | | |

| Employee signature (if required for beneficiary change) | Date signed |
|---|---|
| | |

## 9. BANKING CHANGE / PRE-AUTHORIZED DEBIT (PAD)

Use only if your plan requires banking details for reimbursements or authorized payments. **Attach a void cheque or bank-issued direct deposit form**. Do not provide banking passwords or PINs.

| Account holder name | Financial institution | Account number |
|---|---|---|
| | | |

| Branch / transit number (5 digits) | Institution number (3 digits) | Change type |
|---|---|---|
| | | ☐ New ☐ Update ☐ Cancel PAD |

Authorization: I authorize the applicable deposit and/or pre-authorized debit arrangement to be updated using the information above, subject to plan terms and any required separate PAD agreement.

| Account holder signature | Date signed |
|---|---|
| | |

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## 10. COORDINATION OF SPOUSAL BENEFITS

Complete if your spouse has coverage under another group plan.

☐ Add coordination ☐ Remove coordination

| Spouse's insurer: | Policy number: |
|---|---|
| | |

**Health:** ☐ Single ☐ Family **Dental:** ☐ Single ☐ Family

CLHIA guidelines: A spouse must first claim from their own employer's plan. Covered children must first claim from the plan of the parent whose birthday falls earlier in the calendar year.

## 11. COVERAGE OPT-IN / OPT-OUT

### OPT IN - Loss of spousal coverage

| Date spousal coverage ended |
|---|
| |

Benefits lost: ☐ Extended Health ☐ Dental

Enrollment must be received by Health Risk Services within 31 days following the loss of spousal coverage, or the employee and/or their dependants will be considered late applicants. Attach proof of loss of spousal coverage.

### OPT OUT - If permitted by your plan

Benefits to waive: ☐ Extended Health ☐ Dental

| Spouse's insurer |
|---|
| |

| Policy / certificate number |
|---|
| |

**Employees may only opt out of Extended Health Care coverage only if covered as a dependant through their spouse's group insurance plan.**

## SUPPORTING DOCUMENTS - ATTACH WITH YOUR FORM

**You may be required to provide proof of the change requested, such as a marriage certificate, common-law declaration, birth or adoption certificate, or legal name-change document. Attach applicable supporting documents when returning this form. Your plan administrator may request additional documentation.**

Dependant eligibility: A child aged 21-26 may need proof of full-time post-secondary student status. Disabled dependant certification may be required. Confirm requirements with your plan administrator.

## 12. EMPLOYEE DECLARATION AND SIGNATURE

**I certify that the information provided is true, correct and complete to the best of my knowledge. I understand that changes are subject to group benefits plan terms and may require supporting documentation or insurer approval.**

| Employee / plan member signature | Date signed |
|---|---|
| Employer / plan administrator notes (optional) | Date received |