

**Policy Number(s):** \_\_\_\_\_

**COMPLETE THIS FORM IN BLOCK LETTERS USING INK. FORMS WITH PENCIL WILL NOT BE ACCEPTED**

**A. Employee Information**

Employer's Name: _____					
Employee Division N°: _____		Employee Unit N°: _____		Employee Certificate N°: _____	
<b>Last Name:</b>				Sex	<b>Birth Date</b>
					D M Y
<b>First Name:</b>				<input type="checkbox"/> M <input type="checkbox"/> F	

**B. Spouse Information/Coordination of Benefit**

<b>Last Name:</b>				Sex	<b>Birth Date</b>
					D M Y
<b>First Name:</b>				<input type="checkbox"/> M <input type="checkbox"/> F	

Does your spouse have access to **health coverage**?  Yes - **Check one:** Family Single Waived  
 No - **Check one:** Unemployed Coverage not offered by employer

Does your spouse have access to **dental coverage**?  Yes - **Check one:** Family Single Waived  
 No - **Check one:** Unemployed Coverage not offered by employer

Name of Spouse's Employer: \_\_\_\_\_

**C. Employee Authorization**

**I declare** that the statements I have made on this form are true and complete.

**I understand** that spousal claims are only to be submitted where my spouse is not insured elsewhere or where a portion of the claim is not reimbursed under my spouses plan. I understand that dependent claims should first be submitted to the plan of the parent whose day and month of birth comes earlier in the year, and that only the portion not reimbursed may then be submitted to my plan.

**I understand** that if I waive benefits now and wish to reinstate my benefits in the future, I will be required to provide at my expense, satisfactory evidence of insurability.

**I understand** that the above information may be audited and at such time, I may be required to validate the above declarations

**I understand** that if it is found that I have provided misleading or fraudulent information and / or am unable to validate my declarations on this form that I may be required to reimburse my employer for all spousal and dependent claims retroactive to my hire date, in addition to any costs related directly to the recovery of such funds.

Name (Please Print) \_\_\_\_\_ Signature \_\_\_\_\_ Date (dd/mm/yyyy) \_\_\_\_\_