HealthSource Plus
Group Health Insurance - Benefit Administration

# Change Report

**HSP Form No.2**
04.7

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

## A. Employer Information

| Employer's name: | | Policy N°: |
|---|---|---|
| Division N°: | Unit N°: | Employee Certificate N°: |

## B. Employee Information (PLEASE PRINT IN BLOCK LETTERS)

| | | Sex | Birth Date | | |
|---|---|---|---|---|---|
| **Last Name**: | | | D | M | Y |
| **First Name**: | | ☐ M ☐ F | | | |

Language Preference: ☐ English ☐ French

**Mailing Address:**
Street, Suite N° City Province Postal Code

| Work E-mail: | Home E-mail: |
|---|---|

## C. Type of Change (please enter the type of change number and provide explanation below)

| | | | |
|---|---|---|---|
| 1 | Temporary Layoff | 7 | Adding or removing dependents - Complete sections F and/or G |
| 2 | Return from Temporary Layoff | 8 | Salary Change - Show new salary in explanation Section |
| 3 | Termination – Indicate last day worked | 9 | Beneficiary Change - Complete Beneficiary Designation section D |
| 4 | Reinstatement/Rehire - (Complete new enrolment form) | 10 | Division Transfer - Indicate old and new division in explanation section |
| 5 | Unit Change – Show old and new unit in explanation section | 11 | Other – Provide details in explanation section |
| 6 | Change in Coverage – Complete sections E, F and/or G | | |

### Employee Benefit Change Information

| Type of Change N°. | Effective Date | | | Explanation |
|---|---|---|---|---|
| | D | M | Y | |
| | | | | |
| | | | | |

## D. New Beneficiary Designation - If a Minor Beneficiary is appointed, you may wish to complete the Trustee Clause Section below

| Last Name | First Name | Employee Relationship | % |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**For Quebec Residents, if Spouse is beneficiary, their designation is:** ☐ **Revocable** ☐ **Irrevocable**

**Important Note:** The employee is the beneficiary of insurance on the lives of his or her dependents. Unless otherwise stipulated or prohibited by law, the designation is **revocable**. If the beneficiary is shown as **irrevocable**, his/her consent is required to change it. In Quebec the designation of your spouse as beneficiary is Irrevocable unless otherwise specified.

### Minor Clause - Trustee for Children under the age of majority

Trustee Name: ______________________ Relationship to Life Insured: ______________________

As indicated above the trustee is hereby appointed to receive any payment due on or after the life insured's death to any BENEFICIARY DESIGNATED in this form who is a minor on the date such payment(s) fall due.

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## E. Change in Coverage – Indicate new level of coverage requested and complete section(s) F and/or G

**HEALTH**: ☐ Family ☐ Single ☐ Waive * **(Waiver due to spousal coverage - complete section(s) F and/or G)***

**DENTAL**: ☐ Family ☐ Single ☐ Waive * **(Waiver due to spousal coverage - complete section(s) F and/or G)***

| **Effective date of Change:** | **Reason for Change:** |
|---|---|

***Important: Health and/or Dental benefits can only be waived if you and/or your dependents are covered by a spousal plan.**
**If spousal coverage is lost, you must apply for coverage within 31 days of loss, or proof of insurability will be required.**

## F. Spouse/Partner Coverage Information (for Family Coverage or Waiving)

| | | Sex | Birth Date | | | |
|---|---|---|---|---|---|---|
| | | | D | M | Y | |
| **Last Name**: | | | | | | ☐ Add<br>☐ Remove |
| **First Name:** | | ☐ M<br>☐ F | | | | |

Does your spouse have coverage with another insurer? ☐ Yes ☐ No
Name of Insurance Co.:
Name of Spouse's Employer:
Policy or Group N°:

**My spouse has: HEALTH**: ☐ Family ☐ Single ☐ None

**My spouse has: DENTAL** : ☐ Family ☐ Single ☐ None

## G. Dependent Children Information

| Dependent's Last Name, First Name | Add or Remove | Sex | Birth Date | | | If child is 22 or over, indicate if disabled or student. **If student, attach proof of schooling.** |
|---|---|---|---|---|---|---|
| | | | D | M | Y | |
| | ☐ Add<br>☐ Remove | ☐ M<br>☐ F | | | | Disabled: ☐ Yes ☐ No<br>Student: ☐ Yes ☐ No |
| | ☐ Add<br>☐ Remove | ☐ M<br>☐ F | | | | Disabled: ☐ Yes ☐ No<br>Student: ☐ Yes ☐ No |
| | ☐ Add<br>☐ Remove | ☐ M<br>☐ F | | | | Disabled: ☐ Yes ☐ No<br>Student: ☐ Yes ☐ No |
| | ☐ Add<br>☐ Remove | ☐ M<br>☐ F | | | | Disabled: ☐ Yes ☐ No<br>Student: ☐ Yes ☐ No |

## Employee Authorization

**I declare** that the statements I have made on this form are true and complete. I understand that if any statement is incomplete or false and/or if I do not abide by the terms and conditions as set forth in the insurance policy and/or this application for insurance, my benefits may be terminated.
**I certify** that I am authorized to disclose and receive information about my spouse and/or my dependent children.
**I hereby** authorize Health Source Plus Inc. as the administrator of my group health insurance plan to receive and maintain a record of the personal health information and claims history for myself and my dependents, and of my social insurance number (where applicable) on behalf of my employer and use such information to:

a) Verify eligibility & identify myself and/or my dependents;
b) Ensure my benefits are paid in accordance with the policy provisions;
c) Protect the plan from undue expenses due to error or fraud;
d) To allow my employer to audit, review and analyze claims trends as required.

**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 Health Source Plus Inc. shall have the right to recover from myself and/or my dependents any payments made in error or as a result of fraud, as well as any costs related directly to the recovery of such funds.
**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 and subject to the sole discretion of Health Source Plus Inc. my benefits may be reinstated.
**I authorize** my employer to deduct from my payroll any portion of the benefits program which I may be required to pay.

Name (Please Print) Signature Date Signed (dd/mm/yyyy)

## Employer Authorization

**I declare** that the information provided on this form is complete and accurate to the best of my knowledge, and **I authorize** Health Source Plus to use this information to administer the group benefits plan; obtain quotes for underwritten/insured products within the plan; verify the identity and eligibility of the plan member, spouse or eligible dependents; adjudicate and pay eligible claims; audit plan expenditures; and, prepare reports.
**I understand** this information will only be provided to those insurers/adjudicators contracted by Health Source Plus to provide services within the plan.
**I declare** that I have obtained the Consent of this Employee (and the consent of the spouse or partner where applicable) to provide this information to Health Source Plus.

Name (Please Print) Signature Date Signed (dd/mm/yyyy)