

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)						
Last Name:		Sex	Birth Date			
			D	M	Y	
First Name:		<input type="checkbox"/> M				
		<input type="checkbox"/> F				
Language Preference: <input type="checkbox"/> English <input type="checkbox"/> 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
2	Return from Temporary Layoff
3	Termination – Indicate last day worked
4	Reinstatement/Rehire - (Complete new enrolment form)
5	Unit Change – Show old and new unit in explanation section
6	Change in Coverage – Complete sections E, F and/or G
7	Adding or removing dependents - Complete sections F and/or G
8	Salary Change - Show new salary in explanation Section
9	Beneficiary Change - Complete Beneficiary Designation section D
10	Division Transfer - Indicate old and new division in explanation section
11	Other – Provide details in explanation section

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.

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)

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

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

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	
	<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> M <input type="checkbox"/> F				Disabled: <input type="checkbox"/> Yes <input type="checkbox"/> No Student: <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> M <input type="checkbox"/> F				Disabled: <input type="checkbox"/> Yes <input type="checkbox"/> No Student: <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> M <input type="checkbox"/> F				Disabled: <input type="checkbox"/> Yes <input type="checkbox"/> No Student: <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> M <input type="checkbox"/> F				Disabled: <input type="checkbox"/> Yes <input type="checkbox"/> No Student: <input type="checkbox"/> Yes <input type="checkbox"/> 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)