



Dependent Status Change

Western Canada

500-2755 Lougheed Highway, Port Coquitlam, BC V3B 5Y9
 Fax: 604.464.7997 Toll Free: 800.667.1336

Eastern Canada

3-55 Rideau Street, Kingston, ON K7K 2Z8
 Fax: 613.530.3770 Toll Free: 888.272.0414

Name of Employer:

► *To use this form you must already be insured under your employer's plan. For a new enrolment complete a Group Insurance Enrollment form.* ◀

► Employee – Complete this section ◀

Employee Last Name		First Name		Initial		Are you covered under your Provincial Health Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Dep. No.	List Dependents			Sex	Birth Date			Relationship to You	If child is over plan's age limit (e.g. 19 or 21), and attending school full-time, provide name of school. If
	Last Name	First Name	Initial	M/F	Month	Day	Year		
01	Spouse								
02	1st Child								
03	2nd Child								
04	3rd Child								
05	4th Child								

Reason for Dependent Status Change (check one and provide details)

<input type="checkbox"/> Marriage (complete dependent information) Date of marriage _____	<input type="checkbox"/> Common Law Spouse (complete dependent information) Date of cohabitation _____
<input type="checkbox"/> Birth or Adoption of Child (complete dependent information) If adoption, provide date _____	<input type="checkbox"/> Child(ren) of Common Law Spouse (must reside with you – complete dependent information) Date of acquiring dependent(s) _____
<input type="checkbox"/> Separation Date of separation _____ Is spouse still to be covered? <input type="checkbox"/> Yes <input type="checkbox"/> No Are children still to be covered? <input type="checkbox"/> Yes <input type="checkbox"/> No (if no, complete Partial Waiver section)	<input type="checkbox"/> Death of Dependent Date of death _____ Dependent Name _____ Relationship _____
<input type="checkbox"/> Divorce Date of divorce _____ Is former spouse still to be covered? <input type="checkbox"/> Yes <input type="checkbox"/> No Are children still to be covered? <input type="checkbox"/> Yes <input type="checkbox"/> No (if no, complete Partial Waiver section)	<input type="checkbox"/> Other (specify – include date of change) _____ _____

Partial Waiver

► Employee – Complete for partial waiver due to coverage under another group plan ◀

Employee Last Name		First Name		Initial		Are you covered under your Provincial Health Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No					
I elect to waive the benefits checked below because comparable coverage is provided to me and/or my dependents under another group plan: (specify plan details below)											
► For myself and my dependents <input type="checkbox"/> Extended Health Care <input type="checkbox"/> Dental Care				OR				► For my dependents only <input type="checkbox"/> Extended Health Care <input type="checkbox"/> Dental Care			
Name of Other Plan's Employer/Policyholder				Is this your spouse's group plan? <input type="checkbox"/> Yes <input type="checkbox"/> No (if no, provide details)				Name of Insurance Company			
Group Number								Identity Number			