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
107 – 6 Cataraqui Street, Kingston, ON K7K 1Z7
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? ☐ Yes ☐ No

Dep. No.	List Dependents Last Name	First Name	Initial	Sex M/F	Birth Date Month	Day	Year	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
01	Spouse								
02	1st Child								
03	2nd Child								
04	3rd Child								
05	4th Child								

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

☐ Marriage (complete dependent information)
Date of marriage ______________________

☐ Common Law Spouse (complete dependent information)
Date of cohabitation ______________________

☐ Birth or Adoption of Child (complete dependent information)
If adoption, provide date ______________________

☐ Child(ren) of Common Law Spouse
(must reside with you – complete dependent information)
Date of acquiring dependent(s) ______________________

☐ Separation
Date of separation ______________________
Is spouse still to be covered? ☐ Yes ☐ No
Are children still to be covered? ☐ Yes ☐ No
(if no, complete Partial Waiver section)

☐ Death of Dependent
Date of death ______________________
Dependent Name ______________________
Relationship ______________________

☐ Divorce
Date of divorce______________________
Is former spouse still to be covered? ☐ Yes ☐ No
Are children still to be covered? ☐ Yes ☐ No
(if no, complete Partial Waiver section)

☐ Other (specify – include date of change)
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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? ☐ Yes ☐ 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............☐ Extended Health Care ☐ Dental Care **OR** ▶ For my dependents only......................☐ Extended Health Care ☐ Dental Care

Name of Other Plan's Employer/Policyholder		Is this your spouse's group plan? ☐ Yes ☐ No (if no, provide details)
Name of Insurance Company		
Group Number	Identity Number	