MEMBER CHANGE FORM

Suite 200 – 5970 Centre Street SE
Calgary, AB T2H 0C1
Toll Free: 1-800-661-6195
Fax: 403-228-1968

General Information

Plan Sponsor Name: _____ Policy Number: _____

Member Name: _____ Personal Identification Number: _____

Name Change

From: _____ To: _____
First Name Last Name First Name Last Name

Address Change

_____ _____ _____ _____ Effective Date: (YYYY/MM/DD) _____
Member Address City Province Postal Code

Dependent Change

Effective Date of Change: (YYYY/MM/DD) _____

Reason: ☐ Birth of Child ☐ Marriage ☐ Cohabitation Date of Marriage/Cohabitation: (YYYY/MM/DD) _____

☐ Other (Please specify): _____

Add	Delete	Relationship To Member Spouse /Child			Male	Female	*Full Time Student	*Overaged Disabled Dependent
☐	☐	_____	_____ First Name Last Name	(YYYY/MM/DD) Date of Birth	☐	☐	☐	☐
☐	☐	_____	_____ First Name Last Name	(YYYY/MM/DD) Date of Birth	☐	☐	☐	☐
☐	☐	_____	_____ First Name Last Name	(YYYY/MM/DD) Date of Birth	☐	☐	☐	☐
☐	☐	_____	_____ First Name Last Name	(YYYY/MM/DD) Date of Birth	☐	☐	☐	☐

*See Plan Administrator for additional form

Addition of Group Health and/or Dental Benefits

If you have previously waived coverage and have now lost the benefits under your spousal plan or second job, you may apply to be enrolled under your group plan within 31 days of loss. Effective Date of loss of coverage through spousal plan: (YYYY/MM/DD) _____

Waiver of Health and/or Dental Benefits

Note: Health and/or Dental coverage can only be refused if you and/or your dependents are covered by another group benefits plan through your spouse's employer or a second job. If you lose coverage under your spouse's plan, you must apply for coverage under your group plan within 31 days of loss of coverage. **If you do not apply within 31 days, you may be required to submit medical evidence of insurability.**

I understand the plan of group benefits offered to me, but I **decline** to participate in the following benefits:

Extended Health Care and Dental ☐ myself and my dependents ☐ my dependents only

Spouse's Plan Sponsor Name: _____ Name of Insurer: _____

Effective Date of Change: (YYYY/MM/DD) _____ Group Policy Number: _____

Member Authorization

Member Signature: _____ **Date:** (YYYY/MM/DD) _____

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