HealthSource Plus

HealthSource Plus is a People Corporation company

GROUP CHANGE FORM

Please print clearly, use INK, sign and date the form.

1 EMPLOYEE INFORMATION. To be completed by Employee.

Company Name	Employee Name (first name, last name)	Certificate Number

INSTRUCTIONS GUIDE

Completed original forms should be saved in employee files.

Type of Change Requested	Complete Section(s)
A) Change Employee's Name or Address	2, 6
B) Change in Dependent Coverage	3, 4, 5, 6
C) Coverage Refusal or Waiver/Notice for Coordination of Benefits	4, 5, 6
D) Other	

Please complete all required sections clearly to ensure accurate and timely processing of your change request

Type of Change (indicate letter above)	Effective date (dd/mm/yy)	Comments (provide details of change)

2 ADDRESS INFORMATION. To be completed by Employee.

Employee Last Name	Employee First Name	☐ Male ☐ Female
Street Address	Suite Number	
City	Province / Postal Code / Employee Email Address	

Print clearly, to ensure accurate entry of your information.

Please ensure your full and complete address is provided including the postal code.

3 FAMILY DETAILS. To be completed by Employee

What type of coverage are you applying for? (check one)	☐ None (please complete Refusal of Coverage section)	☐ Single	☐ Family	☐ Couple	☐ Single Parent

If you have questions on the type of coverage to select, please speak to your plan administrator

Please Add ☐ **Please remove** ☐

Spouse Last Name, First Name	Gender ☐Male ☐Female	Date of Birth (dd/mm/yy)

Print clearly, to ensure accurate entry of your information.

Are any of your dependents OVER AGE DEPENDENTS? (over the maximum age for a child, as noted in your contract, and either disabled or enrolled in a full-time post secondary institute)

If they are a student, please include current proof of full-time enrolment. **If they are disabled**, please contact your plan administrator for the required forms for completion

Please Add ☐

Child Last Name	Child First Name	Gender	Date of birth (dd/mm/yy)	Overage Student	Disabled
		☐Male ☐Female		☐Yes ☐No	☐ Yes ☐ No
		☐Male ☐Female		☐Yes ☐No	☐ Yes ☐ No
Please Remove ☐					
		☐Male ☐Female		☐Yes ☐No	☐ Yes ☐ No
		☐Male ☐Female		☐Yes ☐No	☐ Yes ☐ No

Please ensure all eligible dependent information is included at time of change, to avoid delays in entry, or late applicant restrictions later.

When providing school information for Over Age Dependents, please ensure it clearly indicates dependent name, enrolment period, and confirmation of full-time enrolment status.

4 COORDINATION OF BENEFITS. To be completed by Employee

If you, your spouse or your dependents are covered for Extended Health Care and/or Dental Care benefits under another group insurance plan please complete this section.

Extended Health Care	☐ None	☐ Single	☐ Family	☐ Couple	☐ Single Parent
Dental	☐ None	☐ Single	☐ Family	☐ Couple	☐ Single Parent

Coordination coverage may include spousal plan, alternate employer, etc.

If an employee has coverage under two group plans, as the primary plan member, the plan with the earlier effective date will be first payer

5 REFUSAL OF COVERAGE. To be completed by Employee, if applicable.

If you or your dependents are presently covered for Extended Health Care and/or Dental Care benefits under another group insurance program you ma refuse Extended Health or Dental Care coverage by selecting the applicable box for each benefit:

I am refusing coverage for:	DENTAL ☐ Myself & My Dependents ☐ My Dependents only	**HEALTH** ☐ Myself & My Dependents ☐ My Dependents only

MUST ANSWER IF YOU ARE REFUSING HEALTH AND DENTAL COVERAGE:

Are you or your dependents now covered by any other group plan? Yes ☐ No ☐

If yes: Policy holder's name: _____ Carrier_____

I understand that I am refusing insurance because myself and/or my dependents are insured under another applicable insurance plan.

Should I wish to join this plan at a later date, I understand that I must request enrollment within 31 days following the termination of other applicable insurance plan or approved life event.

If Dental coverage is refused, I understand that my benefits may be reduced if I later wish to enroll for this coverage.

I understand that I may be required to provide, at my expense, evidence of insurability satisfactory to the insurer, if later wish to enroll in any other coverage that is now being refused.

_____ DATE OF REFUSAL

_____ SIGNATURE IF REFUSING ANY COVERAGE

Only health and dental coverage may be refused, if the employee and/or dependents have coverage elsewhere.

All other benefits are mandatory.

For any questions, please contact your Plan Administrator.

6 Authorizations & Declarations. To be completed by Employee (sign and date in ink).

1. I declare that the information I have provided on this form is true and complete, and understand that if any of the information provided is incomplete or false my benefits may be terminated.
2. A photocopy or electronic version of this authorization is as valid as the original.
3. I certify that I am authorized to disclose and receive information about my Spouse and/or Dependents.
4. I authorize my Plan Administrator (HealthSource Plus) to use my social insurance number for tax reporting purposes and as an identification number where required for the administration of the plan.
5. I authorize my Plan Administrator (HealthSource Plus), its agents, insurers and service providers to use and exchange information collected in this form to underwrite, administer, determine eligibility and adjudicate claims.
6. I authorize my Plan Administrator (HealthSource Plus), Plan Sponsor as required, to use the information collected in this form to make any necessary payroll deductions which may be required.
7. I understand that the Plan Administrator shall have the right to recover from me any payments made in error.

Plan Member Signature	**Date** DD/MM/YYYY

Employer Acknowledgement. To be completed by Plan Administrator.

Name	**Signature**	**Date** DD/MM/YYYY

ABOUT YOUR PRIVACY: At HealthSource Plus, we recognize and respect the importance of privacy. Any information you provide us will be kept in a group life and health benefits file. We limit access to personal information to authorized staff or persons authorized by HealthSource Plus who require it to perform their duties, to persons you have granted access, and to persons authorized by law. We use the information you provide us for the administration, eligibility and adjudication of your benefits under your plan.