

Employee's signature

## **NOTICE OF CHANGE IN COVERAGE** Add/Terminate Optional Dental Care Benefit All changes in employee status must be submitted within 31 days from

Date

		the date	of the event, if i	not, proo	t ot i	nsui	rability may be re	questea by	the insurer						
			AD	MINIST	RAT	IVE	INFORMATIO	N							
Employer/F	Policyho	lder name						Group/Division No.							
Employee's last name						First name					Certificate No.				
Address (N	lo. / Stre	eet / Apt.)			<b> </b>										
City Province							Posta	I code Te		elephone					
	Quebec Residents 🛩 L	ing this	this section, please refer to the « BILL 33 » document on reverse												
REQUIRED COVERAGE AND INFORMATION ON SPOUSE AND/OR CHILDREN															
Health ca	Health care: Single Single parent Couple Defamily Opt-out – Reason:														
Depender (if it is part			Do you want to cover your dependent for Dependent Life benefit? Yes No (This benefit may be mandatory with some insurers if you have eligible spouse and/or children)												
, ,			I want to add this benefit												
			Selected coverage : Single Single parent Couple Family												
		Care Benefit : our plan and	This benefit must be maintained for a 24 month period for yourself and your dependents, unless there is a change related to the eligibility conditions specified in the main policy.												
under its o															
I want to terminate this benefit I want to terminate this benefit for my dependents only I want to terminate this benefit for my dependent on the want to terminate this benefit for my dependent on the want to terminate this benefit for my dependent on the want to terminate this benefit for my dependent on the want to terminate this benefit for my dependent on the want to terminate this benefit for my dependent on the want to terminate this benefit for my dependent on the want to terminate this benefit for my dependent on the want to terminate this benefit for my dependent on the want to terminate this benefit for my dependent on the want to terminate this benefit for my dependent on the want to terminate this benefit for my dependent on the want to terminate this benefit for my dependent on the want to terminate the															
							itions specified in to DREN IDENTIFIC		cy.						
Tł	ne Depe	endent Life benefit coverag	e, if part of your I	olan, may	be n	nand	latory with some in	nsurers if yo	u have eligik	ole spous	se and/or	children.			
You mu	st indic	cate all information regardi	ng your eligible s	pouse an			dren even if you cl	hoose a "Sin	gle" coveraç		ou choose our spouse				
Last name			First name		Sex M F		Date of birth ( YYYY - MM - DD )	If aged 21 or older, please specify		by another plan ?					
										Health care Dental care Yes No Yes No					
Spouse								Full-time student	Handicapped						
Child 1															
Child 2															
Child 3															
Child 4															
Child 5															
Child 6				1-11-1						1-"	<u> </u>				
ir you n	ave an	swered « Yes » to the que This info					ed by another pla e rules for the co			etalis on	the baci	t of this	page.		
LIFE	_ r	Marriage/civil union					Date of marriage/o	ivil union	<b>-</b>			(YYY)	′ - MM - DD )		
EVENTS :	: 🗆 (	Common-law spouse				ı	Date of start of cohabitation		<b>→</b>	( YYYY - MM - DD )					
☐ Separation/divorce						Date of separation/divorce			<b>-</b>	( YYYY - MM - DD )					
	☐ Birth/adoption				Date of birth/adoption			tion	<b>→</b>	( YYYY - MM - DD )					
☐ Adding a full-time student child			hild	Name :				→	( YYYY - MM - DD )						
	☐ Decease			N	lame :				<b>-</b> _	( YYYY - MM - DD )					
☐ End of eligibility of a dependent			dent Name:			: _				( YYYY - MM - DD )					
☐ Coverage by the spousal/parent plan						Start date of coverage			<b>→</b>	( YYYY - MM - DD )					
☐ End of coverage by the spousal/parent plan						End date of coverage			<b>-</b>	( YYYY - MM - DD )					
☐ Involuntary end of spousal/parent coverage						ı	End date of coverage   →				( YYYY - MM - DD )				
☐ Coverage by an educational institution plan						Start date of coverage				( YYYY - MM - DD )					
	☐ Other :					!	Date of change				( YYYY - MM - DD )				
				EMDL C	VEI	=;e	SIGNATURE								

Children covered by another plan – Please provide the following details :								
Indicate for which child the following applies – Child # :								
Health care	Dental care							
<ul> <li>□ Coverage by the plan of current spouse</li> <li>□ Coverage by the plan of the other parent</li> <li>□ Coverage by the plan of the spouse of the other parent</li> <li>□ Coverage by the plan of the other parent and the spouse of the other parent</li> <li>□ Coverage by the plan of an educational institution:</li> <li>□ including drug coverage</li> <li>□ excluding drug coverage</li> </ul>	□ Coverage by the plan of current spouse     □ Coverage by the plan of the other parent     □ Coverage by the plan of the spouse of the other parent     □ Coverage by the plan of the other parent and the spouse of the other parent     □ Coverage by the plan of an educational institution:     □ including drug coverage □ excluding drug coverage							
If the parents are separated, divorced or not living together:	If the parents are separated, divorced or not living together:							
Are you the sole custodial parent? $\ \square$ or	Are you the sole custodial parent?   or							
Does the other parent have sole custodial? ☐ <b>or</b> Do you have shared custody? ☐ If you share custody, please indicate other parent's date of birth :  (YYYY/MMVDD):	Does the other parent have sole custodial? ☐ <b>or</b> Do you have shared custody? ☐ If you share custody, please indicate other parent's date of birth:  (YYYY/MM/DD):							
Indicate for which child the following applies – Child #:								
Health care	Dental care							
□ Coverage by the plan of current spouse □ Coverage by the plan of the other parent □ Coverage by the plan of the spouse of the other parent □ Coverage by the plan of the other parent and the spouse of the other parent □ Coverage by the plan of an educational institution: □ including drug coverage □ excluding drug coverage	□ Coverage by the plan of current spouse     □ Coverage by the plan of the other parent     □ Coverage by the plan of the spouse of the other parent     □ Coverage by the plan of the other parent and the spouse of the other parent     □ Coverage by the plan of an educational institution:     □ including drug coverage □ excluding drug coverage							
If the parents are separated, divorced or not living together:	If the parents are separated, divorced or not living together:							
Are you the sole custodial parent?	Are you the sole custodial parent?   or							
Does the other parent have sole custodial? □ or Do you have shared custody? □ If you share custody, please indicate other parent's date of birth:  (YYYY/MMDD):	Does the other parent have sole custodial? ☐ or Do you have shared custody? ☐ If you share custody, please indicate other parent's date of birth:  (YYYY/MM/DD):							
	Initials :							

## QUEBEC RESIDENTS ONLY BILL 33 - « DID YOU KNOW ... »

- ✓ On January 1<sup>st</sup>, 1997, Bill 33 (Quebec Universal Drug Plan) became effective for all Quebec residents.
- ✓ All Quebec residents under 65 years of age that have access to a group insurance plan, are obliged to join the group plan. If a person is covered by another group plan or if a person is covered by a spouse's group plan, proof of such coverage must be filed with your employer.
- ✓ On the group insurance application form with your employer, you are obliged to insure all eligible dependents, spouse and children, unless these dependents are already covered by another group plan.
- ✓ Your eligible dependents cannot be insured with R.A.M.Q. (Quebec Universal Drug Plan) if you are covered by your employer's group plan, with the exception of a spouse, aged 65 years and over.
- ✓ When filing your Quebec tax return, you will be asked if you have met the requirements according to this law.

For further information, please do not hesitate to contact Customer Service at the following numbers:

Montreal area: 514-935-5444 Elsewhere in Quebec: 1 800 363-6217 Fax: 514-935-1147