Benefits Change Form

Part 1: Employee Identification

EmŁJl2èeeĺă Laăű Name	First Name	Initial	District #	Employee ID number	Provincial Health Plan Number (Care Card)

Part 2: Change in Family Status

Change of coverage requested due to the foll2ǿing ǿeðenűéʏ

Date of Event (yyyy/mm/dd)

Marriage Cohabitation Divorce Separation Death Birth Adoption

Other (specify):

Revised Extended Health Coverage	Revised Dental Coverage
Single Couple Family Waived (attach Waiver of Coverage form)	Single Couple Family Waived (attach Waiver of Coverage form)

Add	Delete	No.	Dependenűűă Fiłlăű Name	Initial	Last Name (if different from Employee)	Birthdate (yyyy/mm/dd)	Relationship	Gender M ς Male F ς Female X ς Another Gender U ς Prefer Not to Disclose	Provide name of school and student number if child is over 21 and studying full-time. If child is disabled, indicate ǿdiăabledé in űhiă ăecűi2n and attach the approved CRA/PWD (Persons with Disability) document. If adding an adopted child, provide date of adoption. If adding a legal ward, provide court document.

Part 3: Change to Spousal or Other Coverage

Change of Dental Extended Health coverage requested due to:

Date of Change (yyyy/mm/dd)